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Review

Suicide whilst under GMC's fitness to practise investigation: Were those deaths preventable?

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ABSTRACT

The suicide of doctors under regulatory investigation in the United Kingdom has recently been under scrutiny. Despite a commissioned report into the issues surrounding these deaths, we discuss a variety of procedural and legal lacunae not yet openly considered for reform. We identified that the UK coronial system has in place several legal instruments requiring coroners to report the physician suicides as preventable to the regulatory body, the General Medical Council (GMC). We were unable to identify that these suicides were reported in line with established legislation. We also explored the relationship between the GMC and its registered doctors, concluding that the GMC does indeed have a duty of care towards its members on this important matter and that there should be procedural reform to tackle the inherent risk of suicide whilst under investigation.

1. Introduction

28 doctors committed suicide between 2005 and 2013 whilst under fitness-to-practise (FTP) investigations. These were the alarming and distressing figures revealed following a Freedom of Information (FOI) request made independently to the General Medical Council (GMC) in 2012 by a psychiatrist, Dr Helen Bright.[1] The reasons for the suicide are multitudinous. However, a common theme is the stress and threat of investigation by the GMC and the painfully named 'death by 1000 arrows'[2] associated with an almost simultaneous investigation by various other authorities. This may include the police, an employer, the Clinical Commissioning Group, NHS England, and the Local Medical Committee. These deaths were not contemporaneously highlighted as preventable and only recently made public.

In this article, we seek to explore whether these deaths could indeed have been averted, and if so, by whom and how. Part 2 below will discuss how far FTP investigations should be recognised as a distinct suicide risk factor. By analysing firstly the high rate of suicide among doctors in general, the discussion will then assess the extent to which ongoing FTP investigation either exacerbates existing suicide tendencies or poses as an abnormally insurmountable challenge, so much so that it warrants consideration as an independent risk factor for physician suicide. In Part 3, we will argue that the failure thus far to isolate and recognise FTP investigation as a risk factor has meant that insufficient effort has been made to prevent the death of the affected doctors. The 2 main parties on whose shoulders lie the bulk of the responsibility are the coroners and the GMC itself. We aim to highlight specifically, that none of the deaths were reported by the coroner under Rule 43 of the Coroners Rules 1984 or as Prevention of Future Deaths (PFD) Reports under the Coroners and Justice Act 2009.[3] The reporting of these deaths to the GMC may have promoted brisk, efficacious changes in the manner in which doctors are investigated and may have prevented the loss of lives. Further, even in the absence of a PFD report, it will be argued that the GMC has actual or constructive notice of the cause of death. This, coupled with the gravity of the issue, gives rise to a duty to take appropriate actions to ensure that further suicides are averted. Part 4 reflects on the lessons that need to be urgently learnt from the array of failings to date.

2. FTP investigation: a suicide risk factor?

Following on the heels of the FOI request, the GMC commissioned an independent report in 2013. The aim was to review the deaths of those who committed suicide while under FTP procedures during the time framework examined.[4] It was prepared by Sarndrah Horsfall, who was the Chief Executive for the National

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Patient Safety Agency (NPSA). The report revealed that of the 28 suicides recorded between 2005 and 2013, 20 of these cases were male, two-thirds were under 50 years old, and 2 were trainees.[5] There was an equal preponderance for hospital or general practice doctors. 20 of the doctors were highlighted as having a health concern – thus identifying them as potentially more vulnerable. These 20 doctors were further subdivided - 6 of them were reported to be a suicide risk; 4 did not have evidence of a documented suicide status; and the current health provision status for 2 of the doctors was unknown.[6] In this part of the discussion, we will investigate the extent to which ongoing FTP procedures could have played a significant role in these suicides.

2.1. Physician suicide in general

Doctors have been identified as hard-working, professional members of society.[7] They are perfectionistic, high-achieving and talented with studies confirming that their work and productivity is intimately associated with their perception of self-esteem.[8,9] Most doctors are able to channel this method of working effectively and find ways in which to thrive from their delivery of care to patients. In some circumstances, actual or perceived criticism leads to a collapse of this self-esteem and resultant physical and/or mental health issues associated with low self-esteem including anxiety and depression arise.[10] Doctors may have developed maladaptive methods of coping with the stress associated with the delivery of 'perfect' care and these include alcohol, drugs and reckless behaviour.[11,12] The balance between mental health, physical health and the misuse of alcohol or drugs is unclear.[13] However, this balance may be lost when further stress is added in the form of professional, regulatory investigation.

Several studies have highlighted that medical professionals are a high suicide risk.[14] This risk is greater than in other professions and much greater than the general population.[15] The same studies have also demonstrated that female doctors are high-risk.[16] Overall, there is a higher-rate of mental health problems amongst doctors and studies have demonstrated that even in the absence of regulatory investigation, some 10–20% of doctors are depressed at some point in their careers.[17] Indeed this concern is further highlighted by a recent survey that demonstrated that those doctors subject to complaints were at a markedly increased risk of suicidal thoughts, anxiety and depression.[18]

Recently, the stresses placed upon doctors, even in the absence of regulatory investigation by the GMC, have increased. A report issued by the Royal College of Physicians in 2012[19] demonstrated that currently there are one-third fewer acute trust beds than 25 years ago yet there has been a 37% increase in hospital admissions over 10 years.[20] Two-thirds of patients admitted to hospital are greater than 65 years old and most have complex multimorbidity requiring greater skill, higher levels of care and cautious management.[21] The report also highlighted that buildings, staff and services are not of a calibre designed to cope with this degree of multimorbidity. Amongst all of this, 75% of medical consultants reported being under more pressure than 3 years ago and 25% of medical registrars reported their workload as unmanageable.[22]

In the same survey, half of consultants reported spending less time with these trainees than 3 years ago, exposing a worrying preponderance for lack of supervision due to service commitments, unmanageable workloads in junior staff and a high background risk of anxiety, depression and suicide.[23] Currently, not only are hospital staff suffering from the increased burden from healthcare delivery. It has been reported that general practitioners (GPs) are suffering from the highest levels of stress since 1998 with approximately half of all GPs over 50 planning to retire in the next 5 years.[24] The results of the GP national worklife study revealed that '[GPs have] the lowest levels of job satisfaction … [and] the highest levels of stress'.[25] The subsequent addition of a regulatory investigation can surely be seen to be an additional stress that for some may increase the risk of mental and physical illness and suicide.

There is an extensive body of research behind physician suicides, reflecting the concern and desire to prevent such deaths at intense personal, social and financial cost to society.[26] Most methods of suicide within a medical body reflect what is known about gender differences in suicide.[16] The majority of cases are of self-poisoning or self-harming; with males more likely to undertake physical methods of suicide. Anaesthetists are more likely to use chemical methods of suicide whereas hanging, cutting, shooting and even burning are options taken by some doctors.[27]

Perhaps most worryingly of all is why doctors do not seek help when experiencing difficulties with stress, depression or substance misuse. A 2011 literature review[28] of these reasons revealed that doctors may perceive the need for assistance as a sign of weakness, they may fear regulatory involvement particularly if substance misuse is a method of maladaptive coping or they may attempt to frustrate the natural process of healthcare delivery by the use of 'corridor conversations.'[29] This final point has been demonstrated clearly in the case of Dr Daksha Emson, a consultant psychiatrist who committed suicide. A report into her death and that of her young daughter revealed in 2000 that:

'Daksha was afraid of being stigmatised if others knew of her illness … Her fear would seem well justified, as the NHS was considered by a senior expert in health employment, with experience of both the private sector and the NHS, to be far worse than the private sector for stigmatising mental illness in its employees.'[30]

The report also highlighted that those doctors who are struggling may not receive the true benefit of being treated as a patient, rather than a colleague. It states that 'a large number of doctor-to-doctor consultations are carried out on an informal basis, the "patient" seeking advice from a colleague often without reference to the General Practitioner. Self-medication, particularly of psychotropic medication, is commonplace'.[31] The recommendations made in the array of professional literature discussed, demonstrate how doctors are at high-risk for mental illness and suicide; yet not as able to access conventional methods of healthcare due to perceived stigma or inadequate service provision.

Thus even in the absence of FTP investigations, heavy threats are posed to doctors' health when considering the skill, perfectionistic approach and burdens associated with the delivery of complex healthcare in the UK today. As will next be seen, the addition of pressures associated with regulatory investigation can have a truly harmful effect particularly on those already at high-risk of suicide.

2.2. Suicide whilst under investigation

Although the presumption of innocence operates in FTP investigation just as it does in court, doctors undergoing FTP proceedings often feel that they are judged 'guilty until proven innocent'.[32] This was the agonising experience of those confronted with GMC disciplinary procedures, according to the Horsfall report. Contributing to this perception are multiple causes of stress stemming from various aspects of the procedures, some of which are described below:

- some doctors received multiple letters from the GMC investigation team, with one doctor receiving up to 5 letters over a 4-day period[33];
- many doctors felt that the tone was 'accusatory' with emphasis on legal terminology and a subsequent failure to reflect compassion or recognition of underlying health complaints[34];