

# BMJ Open 'You feel you've been bad, not ill': Sick doctors' experiences of interactions with the General Medical Council

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## ABSTRACT

**Objective:** To explore the views of sick doctors on their experiences with the General Medical Council (GMC) and their perception of the impact of GMC involvement on return to work.

**Design:** Qualitative study.

**Setting:** UK.

**Participants:** Doctors who had been away from work for at least 6 months with physical or mental health problems, drug or alcohol problems, GMC involvement or any combination of these, were eligible for inclusion into the study. Eligible doctors were recruited in conjunction with the Royal Medical Benevolent Fund, the GMC and the Practitioner Health Programme. These organisations approached 77 doctors; 19 participated. Each doctor completed an in-depth semistructured interview. We used a constant comparison method to identify and agree on the coding of data and the identification of central themes.

**Results:** 18 of the 19 participants had a mental health, addiction or substance misuse problem. 14 of the 19 had interacted with the GMC. 4 main themes were identified: perceptions of the GMC as a whole; perceptions of GMC processes; perceived health impacts and suggested improvements. Participants described the GMC processes they experienced as necessary, and some elements as supportive. However, many described contact with the GMC as daunting, confusing and anxiety provoking. Some were unclear about the role of the GMC and felt that GMC communication was unhelpful, particularly the language used in correspondence. Improvements suggested by participants included having separate pathways for doctors with purely health issues, less use of legalistic language, and a more personal approach with for example individualised undertakings or conditions.

**Conclusions:** While participants recognised the need for a regulator, the processes employed by the GMC and the communication style used were often distressing, confusing and perceived to have impacted negatively on their mental health and ability to return to work.

## INTRODUCTION

Many occupational surveys and reports indicate a high prevalence of mental ill health

## Strengths and limitations of this study

- We obtained detailed rich personal accounts from 19 doctors from across the UK who were or had been away from work for more than 6 months, 15 of whom contributed data on their views of the General Medical Council (GMC).
- We identified four discrete themes; our study generated detailed quotations on the feelings generated by the GMC, including clear examples of suggestions for improvements.
- Our methodology meant that we have no way of knowing anything about the doctors who were approached by our partner organisations but decided not to take part. Further, regarding our participants we have only the doctors' own accounts and no independent way of understanding for example the relationship between their initial reason for stopping work and their current problems, nor the precise reason where applicable for their involvement with the regulator.

and addiction in doctors,<sup>1–4</sup> with suicide rates being considerably higher than population averages.<sup>5</sup> This is a problem not only for doctors but also for their patients. Several studies have highlighted the difficulties faced by doctors in taking sick leave, and how this can impact on their subsequent return to work.<sup>6–9</sup> Recent research has identified that the changing role of medical regulators appears to have become a barrier for successful return to work for doctors with complex health problems.<sup>10</sup>

The General Medical Council (GMC) is the regulatory body for doctors in the UK. It has a number of roles aimed at protecting, promoting and maintaining the health of the public. It maintains a register of medical practitioners; sets standards of professional and ethical conduct; and oversees the process of revalidation of doctors.

Doctors can be referred to the GMC by anyone concerned that their fitness to practise (FTP) may be impaired. Doctors can also

self-refer. The GMC's policy document, Good Medical Practice<sup>11</sup> outlines the standards expected of doctors. The GMC website hosts an explanation of what the GMC means by FTP and the reasons a doctor's FTP may be brought into question.<sup>12</sup> Both Good Medical Practice and the FTP document discuss the possibility that ill health might impair a doctor's FTP if 'the doctor does not appear to be following appropriate medical advice about modifying his or her practice as necessary in order to minimise the risk to patients'. The GMC adopts the same investigation procedures whether or not the doctor has been referred for health problems or for misconduct. GMC data suggest that mental health problems are the most common category of health issues leading to FTP investigations.<sup>13</sup> For doctors with mental disorders the GMC may request that two independent psychiatrists assess the doctor and prepare a report, including recommendations regarding FTP and management of the doctor's health problems.

The outcomes of GMC FTP investigations (and the instructions to specialist examiners) are summarised as (1) fit to practise generally; (2) fit to practise with limitations and (c) unfit to practise. Where a doctor with health problems is considered fit to practise only with limitations, he or she is invited to agree to 'Undertakings', which usually include following the recommendations of his or her general practitioner and treating specialists, and consenting to communications between the GMC and those treating the doctor. In some instances, where a doctor's FTP has been found to be impaired they are required to have a GMC supervisor that is, an appropriate specialist who liaises with those treating the doctor and reports regularly to the GMC regarding the doctor's adherence with their restriction on practice, and makes recommendations whether such restrictions should continue. In cases where a doctor is considered currently unfit to practise, he or she is suspended. Suspension may be for a finite time, or indefinite, but this is subject to review.

The Shipman Inquiry heavily criticised the GMC for allegedly acting to protect doctors rather than protecting patients.<sup>14 15</sup> The GMC responded by implementing a number of reforms around its FTP procedures. Recently the Medical Practitioners' Tribunal Service has been established. This has separated the GMC's role in investigating doctors, and its role in holding hearings into such cases.

These reforms have not been universally welcomed. A qualitative study of randomly selected GPs, psychiatrists and others involved in medical regulation,<sup>16</sup> designed to explore views and experiences of transparent forms of medical regulation in practice, described three key emerging themes regarding current medical regulation. The doctors they interviewed described feeling 'guilty until proven innocent', highlighted the excessive transparency of the system which can be distorting<sup>17</sup> and associated this with a 'blame culture'.

Despite the negative responses to the reforms highlighted in previous studies, it is important to keep in

mind that the GMC exists chiefly to protect the public. The GMC therefore has the difficult task of protecting the public in a manner that is humane, fair and transparent for the doctors they seek to regulate. This present study aims to explore doctors' views and experiences of how the GMC deals with these issues, and how doctors perceive an effect of GMC proceedings on their mental health or return to work.

## METHOD

This paper forms part of a wider set of analyses designed to explore doctors' perceptions of obstacles to returning to work after at least 6 months away from work. Our methods and initial findings have previously been reported.<sup>10</sup>

### Study design and participants

Doctors either currently off work for at least 6 months or who had experienced a period of at least 6 months off work that ended within the previous year were eligible for inclusion in the study. Doctors were eligible to participate if absent from work for one or more of the following reasons—psychiatric illness, physical illness, addiction, substance misuse problem or suspension by employer or GMC.

Participants were recruited from the following sources: the Royal Medical Benevolent Fund (a charity which provides financial support and advice to doctors), the Practitioner Health Programme (a service providing confidential care to doctors and dentists with physical or mental health needs) and the GMC (the regulator). We requested that these organisations identified potentially eligible doctors, and sent them an information letter explaining the purpose and design of the study. Potential participants were invited by these partner organisations to make contact with the researcher directly if they were interested in taking part. If still interested after this telephone or email discussion, the doctor was invited for interview.

Semistructured interviews lasting approximately 2 h were conducted.<sup>18</sup> A topic guide, consisting questions on health and illness experiences, work and professional relationships, financial situations, regulatory issues and possibility of return to work was developed. Interviews were digitally recorded and transcribed. Thematic analysis<sup>19</sup> was used to identify patterns and themes by manual coding by two researchers (LdB and SKB) working independently using Nvivo (V.8, QSR International). The researchers compared codes and reached consensus on the emerging themes by discussion leading to a final agreed master list of themes and subthemes. Emerging themes were discussed regularly by the research team. This type of thematic analysis is inductive, that is, the themes emerged from the data itself and were not imposed by the researchers.

Both researchers engaged in a process of reflexivity. They each recorded details of the interviewing

interaction, and reflected on their own experience which may have had an impact on the interpretation of data. A clinician with extensive experience of caring for doctors with mental health problems (Henderson) was available should either the participant or the researcher become distressed, although in practice this was not needed. Support was also available from the wider research team which comprised a balanced mixture of non-clinicians and clinically trained researchers.

### Ethics

In line with the British Psychological Society's (2006) ethical guidelines, participants were informed of their right to withdraw from the interview at any time and assured of their right to confidentiality and anonymity.

### RESULTS

Nineteen participants of the 77 approached took part in the study. Demographic and health information is shown in table 1. Of the 19, 4 were suspended by their employers and 3 were suspended by the GMC.

Fourteen of the participants (73.7%) had experience of dealing with the GMC. Of these, 7 had something positive to say about the GMC. Thematic analysis resulted in the identification of 4 main themes: perceptions of the GMC; GMC processes; impact on health and suggested improvements.

### Perceptions of the GMC

Participants discussed their perceptions of what the GMC is and what it does, and this led us to three important subthemes: the importance of the GMC, support (or

lack of) and understanding (or lack of) of doctors' needs, particularly in the context of mental health.

### Importance of the GMC

Participants acknowledged GMC processes as necessary, particularly in terms of protecting patients. One participant who did not have any GMC involvement had 'always wanted the GMC to be involved' (P18, female, 20s) as she felt she needed 'someone in authority' (P18) to declare if she was fit for work or a danger to her patients. Several other participants suggested it was useful to have this assessment and were grateful for the 'breathing space' they were given if they were declared not fit to work (P19, female, 50s). Participants agreed that the GMC 'needs to exist' (P8, female, 30s).

I would now feel as if I have the weight of the GMC with me, on my behalf and they did deal with me very professionally and at no stage, you know you look back over it, at no stage were patients allowed to be put at risk which is good. (P16, male, 40s)

### Support

Doctors tended to view their GMC experiences as positive when individual GMC supervisors were supportive. Empathy and support were important, with participants more likely to view their experience as positive if they found their supervisors 'easy to talk to and discuss things with' (P2, female, 40s). Other qualities that were appreciated included 'supportive', 'helpful', 'kind' and 'fair'. Some participants felt they would find the process a lot easier if they were able to choose a supportive supervising consultant.

**Table 1** Participant characteristics

Participant number	Age range	Gender	Mental health problem/addiction?	Physical health problem?	GMC involvement?
1	40s	M	Yes	Yes	Yes
2	40s	F	Yes	Yes	Yes
3	40s	F	Yes	No	Yes
4	60s	M	Yes	No	Yes
5	50s	F	Yes	Yes	No
6	20s	F	Yes	Yes	No
7	50s	F	Yes	No	Yes
8	30s	F	Yes	No	Yes
9	40s	M	Yes	No	Yes
10	60s	M	Yes	No	No
11	40s	M	No	Yes	No
12	40s	M	Yes	No	Yes
13	50s	F	Yes	No	Yes
14	30s	F	Yes	No	Yes
15	40s	M	Yes	Yes	Yes
16	40s	M	Yes	No	Yes
17	40s	M	Yes	No	Yes
18	20s	F	Yes	No	No
19	50s	F	Yes	Yes	Yes

F, Female; GMC, General Medical Council; M, Male.

I have found Dr [surname] who's my supervising psychiatrist, she's very kind and I found the whole process has been very good, my advisor at the GMC is very nice, very lovely. (P2, female, 40s)

In my case it [experience with GMC] is excellent, yeah. My supervisor is (...) supportive, helpful. (P12, male, 40s)

However, perceived lack of support from the GMC could be stressful. The GMC was frequently referred to as uncaring, unfriendly and impersonal. It could be perceived as unsupportive about returning to work and several participants felt this was not encouraged.

But as, as regards the GMC sending somebody round saying, "Look why don't we sit down and talk about this? How can we get you back to work?" (...) Zilch. Absolutely zilch. Quite, quite the opposite. The impression I got every year for nine years was; we don't want you working. (P4, male, 60s)

I think that somewhere like the GMC is so big that there may not even be a person who's appropriate to reply and so it just gets lost and gives you the impression that no-one cares because there's nothing set up to help people like me. (...) there is no personal contact, it's all very generic and it's- it was the same with the Foundation School that, everything is so fixed, that any suggestion or any difficulty you have, you get the same generic answer. (P6, female, 20s)

### Understanding

It also appeared important for participants to feel understood by the GMC. However, participants often felt the GMC did not understand mental health problems.

I don't think that the panel have sufficient understanding of mental health issues to draw their own conclusions, so they would go on the report and they would see it as black and white. You're either ill or you're not ill, and you can't be somewhere in between. (P7, female, 50s)

The one disappointment that I have and where I think the GMC didn't help is that they dealt with me as if I were well, and I wasn't, and they don't have any... Yes, they've got their health committee but they punished me for things that I'd done when I wasn't well and it became very punitive. (...) I think because the people on the panel aren't aware of mental illness. Often there's somebody there to give advice, but the actual committee don't have any mental health training. So I don't think that they take it into account. They look at this erratic behaviour and, 'We can't have a doctor behaving like that.' (P7, female, 50s)

The perceived lack of understanding from the GMC reinforced low self-esteem, with participants feeling that they were being judged as 'bad' rather than 'ill'. The 'judgmental' tone perceived by participants negatively affected their confidence.

For somebody with low self esteem it sort of, you know, what's the word I'm looking for, reinforces the- your bad self image and you feel you've been bad. (...) Not, not ill. (P4, male, 60s)

### GMC processes

Participants discussed their experiences of GMC processes, which were described as stressful and confusing. Participants emphasised the 'accusatory' tone and legal jargon in GMC correspondence as being particularly uncomfortable. The duration of the process was also considered stressful. Some participants were left confused about their ability to work during the process.

#### Like a court case

The GMC was often seen as punishing, with GMC processes being perceived as 'like a court case' (P15, male, 40s) where doctors who reported to us a difficulty with health rather than misconduct described being made to feel they had done something wrong. Several participants commented that they felt like criminals throughout the process, and were being punished rather than helped.

Their lawyer is like a prosecution lawyer (...) It's just like you're being damned off the face of the earth. (...) It's the most appalling experience I've ever had in my working career (...) It was like a (...) you know the worst kind of court case you could imagine. (...) You just felt like- you were felt- made- I don't know if it was deliberate but you were made- you felt like a criminal. 'I've committed crimes.' Not that I've been ill. I, I'm actually a criminal here on trial. (...) That's how I felt every time. (P4, male, 60s)

Several other participants described communication from the GMC as overly negative, accusatory and judgemental; they felt that the GMC implied that they were a 'bad' doctor rather than an 'ill' doctor who might need treatment and support.

I have to say that I've been extremely unimpressed with the amount of pressure that they put doctors under. I mean (...) at the end of the day it comes back to what I was saying before. We're still people; we can get ill just like anybody else can. (...) They make you feel like you're a really bad person (...) and you know send you countless letters and it's all... I mean they legally term them so you know which I suppose they have to do but you know it kind of doesn't help when you're already struggling with a whole load of other issues. (P3, female, 40s)

I also feel that they [the GMC] could look at the format of their letters and perhaps (...) make them sound less judgemental and less punishing and a bit more supportive and treat you like a person with an illness rather than somebody who has done something horribly wrong. (P3, female, 40s)



## Correspondence

Participants generally described communication from the GMC as poor, and the formal letters sent to everyone which mention 'allegations' can be stressful for a doctor who has done nothing wrong.

I know there must be situations where people's health has led to negligence, but equally there's negligence and maltreatment that have got nothing to do with people's health. Like myself, whilst I was ill at work, no patient ever came to harm, I didn't do anything to anybody that was wrong. It was always about my health. And I think there should be a separate way of dealing with it. They do, in that the hearings are private and things, but I don't see why you get the same mail merge letter about allegations. (P8, female, 30s)

It's just been very stressful and because it's this whole one procedure and because they obviously have standard forms and things, I keep getting these letters about this allegation against me and it frustrates me so much. There is no allegation. (...) it puts you as if you've done something wrong but actually I've done nothing wrong. All I've done is been ill and made a statement to that effect in accordance with good medical practice so what have I done wrong there? (P14, female, 30s)

The perceived accusatory wording and legal terminology used in GMC letters was described as daunting and added to the feeling that a doctor was being judged or had done something wrong.

The whole process is very stressful because it's...I can say it's all very legal...essentially it's a court case the actual Fitness to Practice Hearing... with prosecuting barristers and then defence barristers and the panel themselves... and all the paperwork is in legalese if that's the right word. (P15, male, 40s)

I think because it has to be in legalese it's actually very frightening, it's a language and I didn't know the language and facing that is very daunting when you suddenly realise that these white envelopes post marked at Manchester arrive for which you have to sign, so it's all very, very formal and that is very daunting in many respects and I can see that a lot of people would get very upset with that indeed. (P17, male, 40s)

Participants acknowledged that, as an official regulatory body, the GMC needs to be formal in its communication; however, they found it daunting, and this contributed to feelings of anxiety at an already stressful time.

The GMC's correspondence was also criticised in terms of showing unawareness of each individual's case: "Some of the letters I got, it was almost like people were sending the letter and weren't aware of my case" (P8, female, 30s). Participants suggested they would like better communication from the GMC, explaining to them what the process will involve, and taking a more

individual approach rather than sending formal letters to everyone.

## Lengthy process and inability to work

Participants referred to GMC proceedings as long and drawn-out. This lengthy, time-consuming process was frustrating and stressful as participants said they often had little or no explanation of why the process was taking so long, and claimed it was hindering their return to work.

They did have an effect on my teaching post. I always left it to my lawyer, but when he was phoning the GMC and was saying we were still waiting on your decision as to the way it is affecting my client's work, there was a sort of a 'Oh that doesn't matter, we can't do it any quicker than we're doing it.' (P8, female, 30s)

Participants were unclear about why the process was so time-consuming.

I felt that they were actually supportive. At times it could drag a bit (...) I'm always waiting for something. (...) I try not to get too fussed about it but it's just that you look at it and think, "Does it really need to take this long?" Maybe it does, I don't know why. (P16, male, 40s)

You know I sat on what was effectively a waiting list for, in effect, eighteen months unable to work, unable to do anything, alone in the wilderness courtesy of GMC procedures. If they could get it on and get sorted, they would save themselves a lot of money, they'd save the NHS a lot of money and they'd save the doctors a lot of anguish and a lot of suffering. (P17, male, 40s)

Two participants reported that the GMC would not allow them to return to clinical practice without supervision, but they could not find anybody prepared to supervise them. Several had had to return to work in non-clinical posts.

The GMC was saying that they couldn't allow me to go back to any type of clinical practice unless I had supervision. (...) My colleague weren't particularly happy about supervising me so that became a problem and there was no way back in through that. The employing Trust wouldn't allow me back in without the GMC saying yes and the GMC wouldn't say yes until I had supervision so I was falling between the two and it took a lot of leverage to try and get that resolved. (P16, male, 40s)

## Impact on health

For some participants, being suspended came as a relief and allowed them time and space to recover without the pressures of work. Several other participants described the GMC process as worsening their mental health. 'Some found that sudden suspension was difficult to cope with—it's not like you're choosing to leave a job. You're suddenly just adrift and I don't know what to do' (P13, female, 50s).

My wife will tell you, she'd say it every year, she'd say "Oh God", she said, "I know when there's a GMC meeting coming up 'cause for about six weeks before you're getting wound up, as soon as the first letter arrives". (P4, male, 60s)

I certainly think that somebody should be having this...a serious look at how the GMC deal with people. (...) because that actually on top of the stress of losing my license (...) was almost unbearable really at times. (...) and certainly it didn't help the fact that I mean I think that cost me a relapse back into drinking, not into depression. So in fact the problem that I had actually overcome, they actually started it off again. I mean I can't blame them for that but they certainly contributed to it. (P3, female, 40s)

Another participant highlighted their response to an interim order panel as a normal response to a stressful experience rather than as a part of their illness:

I was worried that I would get upset, because at times I did get upset when I was speaking to the solicitor and I was worried that I would get upset and they would take that as a sign that I wasn't mentally well, whereas it was just really a sign that it was an overwhelming process—it wasn't anything to do with me being mentally well or not mentally well. (P14, female, 30s)

### Suggested improvements

Several participants made suggestions about what could be done to improve the experience of doctors going through GMC processes. These suggestions included being able to talk to other people in the same situation; transparency—clearer and less impersonal explanations from the GMC; the GMC being more flexible regarding undertakings; and the GMC supporting doctors as well as protecting patients. Participants suggested that undertakings need to be more individualised.

The best way I would have learnt about the process was talking to other people who'd been through it, because to be honest the lawyers weren't particularly helpful (...) to them it's like everyday, it's their job and they do it every day. They lose sight of that and for me it's the first time I've been through any of this. A bit more explanation would help, as I say, speaking to other people who've been through the process particularly helpful. (P15, male, 40s)

I think it's lack of any clarity and any transparency and the fact they have undertakings and conditions which are identical. Undertakings are agreed to, conditions get imposed. But they are identical whether you've actually been stealing class A drugs or whatever so it makes no difference, there's no flexibility and it's a one size fits all which I think is a problem. (P19, female, 50s)

One participant implied that improved cooperation between employing Trusts and the GMC, or Trusts

understanding how the timing of their decisions impacts this process, would be helpful:

They couldn't let me go back to work until they knew there was an offer from the Trust. Really we were waiting for the Trust to come up with an offer and the Trust was waiting for some type of relaxation of undertakings from GMC so the GMC could have maybe relaxed things a little bit sooner because there was really a year wasted and I could have been back to work. (P16, male, 40s)

Participants also suggested that 'snapshot' assessments are unhelpful, and that the GMC should have a good understanding of each individual doctor.

If you look at my assessments they were very snapshot, one particularly so and I only talked to him for about twenty five, thirty minutes (...) You will not ever get someone, in the snapshot. You know, it's never works like that. (P17, male, 40s)

This highlights the importance of individualised contact with the GMC. Some participants also suggested that the GMC should consider the 'positives' for each doctor and not merely focus on the negatives:

I always felt instead of saying what I've got wrong or where I've gone wrong or how I've been unwell, why not look at everything that's good (...) why not speak to some of my bosses, why not contact some of my patients if they're willing to speak (...) instead of writing me off. (P4, male, 60s)

Participants suggested that the GMC should be more encouraging and assure patients that they are not being judged.

It was also suggested that proceedings could be initially handled at a local level, rather than Interim Orders Panels always being held in Manchester or London, which was a long journey for several participants to make. However, they acknowledged that there might be practical reasons for this.

I can understand there are ways of doing it and the GMC need a panel with doctors and lawyers and patients' representatives or whatever. So, but from a sick doctor's point of view: that's a horrendously scary trip to make. (P9, male, 40s)

I think as far as the GMC goes they need to be far more transparent and give us some idea as to what they're trying to achieve basically. (P19, female, 50s)

It is important to note that there were also specific suggestions contained in the themes previously discussed: for example, less legalistic language, more empathy from supervisors, more clarity about the process as a whole and more obviously separate pathways for pure health complaints.

Overall, participants acknowledged the necessity of the GMC process, but many suggested that it is a process which could benefit from improvement.

I think the GMC is good, I think it needs to exist, but I think it needs to come into the modern age a bit. (P8, female, 30s)

## DISCUSSION

We carried out detailed semistructured interviews with nineteen doctors who had been away from work for a variety of reasons for at least 6 months. Fourteen of these had personal experience of GMC procedures, including three who were currently suspended by the GMC.

### Key findings

Our analysis demonstrated that while doctors' experiences with the GMC can be positive, especially with supportive supervisors and caseworkers, GMC processes were often anxiety-provoking and distressing. Our participants described a sense of dealing with what they perceived to be an unaccountable bureaucracy. They described a lack of clear information as well as a lack of consideration of the impact of the tone of correspondence and procedures, particularly regarding referrals for health reasons.

Participants likened the GMC process to a 'court case' where they felt accused, rather than 'ill', echoing the findings of McGivern and Fischer.<sup>16</sup> This perception was not helped by the reported legal language and impersonal tone of GMC letters. It was seen to be a time-consuming and anxiety-provoking process, with little support regarding getting back to work. This was felt to be distressing and even detrimental to health.

The majority of participants interviewed had experience of the GMC and often had strong opinions. While criticisms of the GMC were often firmly worded, participants recognised that the privileges of medicine require a regulatory body, and many accepted that this regulator would have a valid interest in them and their difficulties.

### Study strengths and limitations

Given the nature of the research, we do not know the background to any of the cases discussed here. As with all qualitative research, the aim is to collect participants' perspectives of their experiences. There may be an element of social desirability bias in these interviews, and participants' accounts may have omitted or incorrectly recalled information. We appreciate that while these analyses emerge from a wider study of doctors' perceptions of obstacles to their return to work, doctors who volunteered, may have held with stronger views, either positive or negative about the regulatory process.

All interpretations are our own, and therefore may reflect any biases or interests that we may have. However, we employed various strategies to ensure that the

research was reliable and valid. Reflexivity, a methodological tool to ensure fair and ethical representations, was used, with the researchers continually scrutinising the process and reviewing the research throughout, being constantly aware of the researchers' own theoretical position; and inter-rater reliability was ensured by having two researchers code the data separately.<sup>20 21</sup> However, we acknowledge that meanings are not absolute and that others may have different interpretations of the data. A larger study would be useful in exploring how widespread the experiences and attitudes displayed in this study really are.

Doctors can be referred to the GMC for a wide range of reasons of which health may be one or a part. We do not know the reasons our participants were initially referred to the GMC, though by the time of the study all but one had some form of mental health problem. What we heard though was the perception that GMC communications made even sick doctors feel they had 'done something wrong'.

## Conclusions

The GMC's duty is to protect the public, and it is possible for sick doctors to be a risk to patients. Doctors are no more immune to ill health or its consequences than the people they care for; doctors can be patients too. We identified concerns about the extent to which the GMC understands the specific difficulties posed by mental ill health, and drug and alcohol dependence. The conflation of ill health with misconduct seems at best inappropriate and at worst counter-productive. This discourages self-referral and creates an adversarial system where doctors report being made to feel that by becoming ill they have somehow done wrong. A more supportive, less judgemental, approach would both encourage engagement and might lead to better outcomes. We propose that the GMC should consider the possibility that there may be a health component whenever doctors are referred, and if evidence of ill health is found that doctors are diverted through a separate set of proceedings. If, when the episode of ill health has concluded, issues of conduct remain these can be addressed separately. Our interviews indicate that many participants felt that the GMC lacked understanding of mental disorders and it may be that proceedings should be more sensitive to the needs of doctors with mental disorders.

There were a number of comments from participants about the real workplace impact of GMC sanctions below the level of being 'struck off'. Is it possible that having certain conditions imposed could make it impossible for some doctors ever to return to work, thus making them practically indistinguishable from erasure? This perception of at least one of our participants, reflects our own experience of working with sick doctors, and may be much more widespread. A longitudinal study of the outcomes for doctors who have been through GMC processes would provide valuable data. For example, comparing actual outcomes with those

intended by FTP panels would be instructive both for the regulator and for doctors.

It may be that the nature of the GMC as a regulator means communications with doctors undergoing FTP proceedings will always be anxiety provoking, and a degree of formality is necessary and appropriate. The question our data raises is whether the GMC could pursue some of its regulatory responsibilities in relation to sick doctors without generating the level of fear reported here. Doctors involved in GMC proceedings may feel unable to raise concerns or criticisms about the manner in which the regulator acts for fear of worsening their own situation. This would appear to be an unhealthy position for both doctors and the GMC and we hope that this study can help generate a wider debate about these issues.

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