LETTERS

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SUICIDE AND GMC INVESTIGATION

Preventing stress in doctors under investigation

Hawton comprehensively summarises Sarndrah Horsfall's internal report for the General Medical Council and expresses confidence that a separate health system will support doctors under investigation who have mental health problems, thereby preventing suicides.[1 2] However, this initiative is unlikely to ameliorate the immense stress some doctors experience when subjected to complaint investigations and GMC procedures in particular.

Professor Terence Stephenson recently predicted that most doctors will face a GMC complaint at some point in their career.[3] Although most complaints will be unsubstantiated, these investigations can have far reaching consequences, including lost earnings, lost professional status or reputation, anxiety, depression, insomnia, relationship difficulties, social isolation, suicidal ideation, and death. Such occupational hazards are not acceptable, regardless of the quality of the treatment afterwards. Rather than treating the symptoms, we need to prevent them occurring.

Several factors may contribute to the stress. Our study of 7926 UK doctors showed doctors would welcome a strict time limit on complaints processes, appropriate resourcing of investigations, and clearer and transparent communication.[4] Many doctors felt that they were assumed guilty until proved otherwise and called for this to be reviewed. Many wanted to be able to seek redress for vexatious complaints.

Provision of a support service for doctors is laudable, if both its funding and actions are independent of the GMC. However, the real issue is that there is simply no justification for doctors to be made sick by poor processes—whether by the GMC, hospital trusts, or others, particularly now that we have data that show the risks. The glib statement that such processes are "inevitably stressful" understates the impact of these processes on doctors and may lead to patient care being compromised through defensive practice and a distressed and demotivated workforce.

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Full response at: www.bmj.com/content/350/bmj.h813/rr-2.

1 Hawton K. Suicide in doctors while under fitness to practise investigation. *BMJ* 2015;350:h813. (13 February.)

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Mixed messages from the GMC on disciplinary processes

Hawton mentions emotional resilience training and a doctors' support service as possible solutions to suicides and psychiatric morbidity while under investigation by the General Medical Council.[1] But protracted investigations, fear of professional and personal ruin, and the unnecessary complexity of disciplinary processes might themselves play a part in leading doctors to desperation. If this were the case, the more obvious and practical solution would be to improve these processes.

This is reportedly the GMC's aim, but such an aim is difficult to reconcile with its autumn 2014 consultation on enhanced powers to discipline doctors and its wish to appeal against decisions from the Medical Practitioners Tribunal Service that it considers too lenient. Hence a clear and specific position statement from the GMC on how it sees its procedures developing over the coming years would be welcome.

The aims of being fairer and at the same time assuming greater statutory disciplinary powers seem to be contradictory and at least require explanation.

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Doctors' suicides: economic considerations and beyond

Hawton states that "doctors have long been known to be at risk of suicide."[1] Each such suicide, aside from all the human suffering and pain, costs about £2m (€2.8m; $1.5m).[2] Against this, the General Medical Council's recommendation for £5m to be spent each year for the next three years to provide healthcare support for all registered doctors is but a drop in the distress ocean.

"Doctors cost £500 000 to train, yet no special account is taken of the public need to safeguard this asset."[3] The economics and recommendations of the GMC report are therefore as familiar as they are wearisome—as are the absence of any mention of the NHS's duty of care to its employees and the use of the term "commit" in relation to suicide.[4]

Many medical students are already afraid of GMC procedures, and mindfulness and resilience training are being recommended for them.[5] Yet there is no coherent and systemic strategy to provide safe, sound, and supportive work contexts for all healthcare professionals in medical education and the wider NHS, and thereby to enable this to happen.

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MEET THE ROBODOCS

Misunderstanding the meaning of resilience

McCartney's views on resilience training as advocated by the new head of the General Medical Council, Terence Stephenson, show that she misunderstands the purpose of resilience and resilience training.[1] As a member of the Army Reserve and of my NHS trust's resilience committee, I am disturbed by this misunderstanding—it is particularly poignant that McCartney's piece appeared in an issue of *The BMJ* dealing with suicide and divorce in doctors.

Resilience is not about not complaining, working harder, or unquestioning obedience, nor is it about being a Robodoc. It is about accepting that no matter how good you are, as an individual or a team, things will go wrong, and about developing mechanisms to mitigate the effects of this. The fact that even excellent doctors make mistakes, or that patients and relatives will still complain about doctors who don't make mistakes, and that patients will

still be harmed, is rarely, if ever, mentioned in undergraduate or postgraduate medical training. Resilience training acknowledges this, and allows both individual clinicians and the teams and institutions they work in to plan how to deal with this while minimising adverse effects in those involved and other patients.

As Terence Stephenson says, resilience is something that the military does well, although it is not unique in this. Resilience is something that medical students and young trainees need before something devastating happens, either to themselves or to a colleague. It would be a pity if others in charge of training make the same mistake as McCartney about the meaning of resilience.

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1 McCartney M. Meet the Robodocs: resilient automatons who do as they're told. *BMJ* 2015;350:h566. (2 February.)

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DONATIONS TO EBOLA OUTBREAK

World Bank Group's support to the Ebola virus response effort

Grépin greatly underestimates the World Bank Group's support to the Ebola virus response effort.[1] The International Development Association—our fund for the poorest countries—has committed $518m (£340m; €469m), not $230m, of which $289m (56%), not $117m,[1] has been disbursed to the affected countries and implementing UN and partner agencies. World Bank Group commitments in response to the Ebola crisis total about $1bn overall, including at least $450m from the International Finance Corporation, our private sector arm, to ensure continued business operations and to enable trade, investment, and employment in affected countries. A fact sheet on our website is regularly updated with information on our support.[2]

The Ebola epidemic is a complex humanitarian emergency and the situation on the ground is constantly changing. The World Bank Group continues to expedite disbursement of funds as rapidly as possible in response to the evolving needs and the readiness of governments, UN agencies, and other implementing partners to spend the money effectively. Importantly, our support is geared not only for immediate humanitarian response needs but also for crucial development investments to strengthen weak public health systems in the most affected countries, which contributed to the spread of the epidemic in the first place. The World Bank Group will remain steadfast in delivering support to the affected countries to get to zero cases, recover from this crisis, and rebuild stronger health systems.

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1 Grépin KA. International donations to the Ebola virus outbreak: too little, too late? *BMJ* 2015;350:h376. (3 February.)

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Author's reply

I thank the World Bank for its comment and continued support to those affected by the ongoing Ebola virus crisis in west Africa.[1] I would like to clarify the discrepancy between the bank's figures of total Ebola aid and the estimates cited in my study.[2]

As stated, my study tracked only humanitarian funding, which according to the Financial Tracking Services (FTS) of the UN Office for the Coordination of Humanitarian Affairs, is funding that supports "intervention[s] to help people who are victims of a natural disaster or conflict meet their basic needs and rights." According to the World Bank's website, its aid has been given to "help stop the spread of infections, improve public health systems throughout west Africa, and assist countries in coping with the economic impact." While much of this would be considered humanitarian assistance, most of it would not. This is not to say that these resources are not essential to curbing the spread of the outbreak and alleviating suffering in affected countries—they are.

This is the first time that a public health emergency has been raised to the level of a humanitarian emergency. The current system may not be ideal for tracking resources to this type of response. However, given that it is difficult to know where to draw the line and that the FTS tracks resources to all forms of humanitarian responses and crises, I decided to use the FTS data for this analysis.

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UK SMOKING BAN IN OUTDOOR SPACES

No need for "evidence base" for a smoking ban in outdoor spaces

I support the right of local authorities and institutions to impose and police a ban on any "managed" outdoor spaces visited by the public.[1] With the indoor ban (which


GIULIA FIORI/ALAMY

also generated opposition and the constant invocation of "personal freedom") in place, the air in some public spaces, especially thresholds, is heavily contaminated with cigarette smoke.

A ban in outdoor public places would build on the incredible success of the indoor ban in transforming our physical environment, improving our health status as a nation, and exposing smoking for what it really is—an expensive way of killing yourself and others. A global national ban on all outdoor smoking is probably unreasonable and unenforceable, but the same charge was levelled at the indoor ban only eight years ago. The tobacco lobby is currently winning the war on maintaining the "glamour" of smoking among young people, and it is important to win this particular battle in that war. The degree of outrage from the tobacco lobbyist is always a good indicator of the importance of any smoking control proposal, so this measure and actions like plain packaging are likely to be highly effective in continuing to improve our health and environment.

Plain packaging has clearly been nobbled (temporarily) at the highest political level, and we must anticipate, and be prepared for, the same high level interventions aimed at postponing any extension of smoking control into the external environment. We don't need an "evidence base" for this—it is simply unpleasant and unhealthy to be walking our children in parks and gardens full of cigarette smoke, and it sets a bad example to them. We need to deliver this, no whiffs or butts.

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Full response at: www.bmj.com/content/350/bmj.h958/rr-11.

1 Darzi A, Keown OP, Chapman S. Is a smoking ban in UK parks and outdoor spaces a good idea? *BMJ* 2015;350:h958. (25 February.)

Cite this as: *BMJ* 2015;350:h1442