WELLBEING & WORKPLACE DIGNITY | MODULE 02

Recognising when something is wrong

Use changes in health, behaviour, work and relationships to decide when to pause, seek help or act urgently.

✓ 15 min reading

✓ Full teaching, practical next steps and reflection

✓ Six practice questions with answers and explanations

✓ Complete source list and jurisdiction notes

Prepared for SAS, locally employed and other UK doctors

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Using this module

Independent education

This is general professional information, not individual clinical, legal, employment, immigration, regulatory, tax or pensions advice. Current official instructions and the circumstances of the individual case remain controlling. Practice scores do not establish professional competence or accreditation.

The short answer

You do not need a diagnosis before responding to deterioration. Notice change from baseline, assess immediate safety, ask directly and respectfully, then connect the doctor with the right level of help.

Three next actions

- Name the specific changes you have noticed without interpreting them as weakness.
- Ask whether there is any immediate risk to the doctor, patients or another person.
- Agree a concrete next contact and do not leave an urgent concern as a vague invitation to seek help.

Learning objectives

- Recognise personal and professional warning signs.
- Hold a supportive first conversation without diagnosing.
- Escalate urgent risk while respecting dignity and confidentiality.

Look for changes, not labels

Warning signs can appear in mood, physical health, behaviour, work or relationships. They may include persistent sleep disturbance, panic, hopelessness, tearfulness, irritability, withdrawal, loss of confidence, repeated lateness, missed tasks, unusual checking, increased conflict, presenteeism or reliance on alcohol or medication. None proves a particular diagnosis. The significance comes from change, persistence, context and impact.

Some doctors continue to perform while becoming increasingly unwell. Seniority and professional knowledge can make it easier to conceal difficulty or self-treat. A spotless clinical record therefore does not rule out serious distress. Equally, an error or complaint does not prove illness. Approach the person, not a presumed diagnosis.

Have a calm first conversation

Choose privacy and enough time. Begin with observable facts, express concern and listen: 'I have noticed you have missed two meetings and seem very unlike yourself. I wanted to check how you are.' Avoid minimising, interrogating or immediately explaining the problem. Ask what would help today and whether the person feels safe.

If there are indications of self-harm or suicide, asking directly does not create the idea. Use clear language and seek urgent clinical help when risk is immediate. Do not promise secrecy you cannot maintain. Explain that you will involve the minimum necessary people to keep them or others safe.

Separate health from immediate clinical safety

A doctor can need health support without being unsafe to practise. Conversely, acute impairment from exhaustion, illness, substances or severe distress may require immediate relief from clinical duties. The priority is safe care and humane support, not punishment. Use the clinical chain of command and local policy to arrange cover, assessment and transport if required.

Do not ask an acutely distressed colleague to drive home alone or finish a shift simply to preserve the rota. Record only what is necessary for the safety action. Employment, occupational-health and regulatory questions can be considered later with appropriate advice; the immediate response should not turn into an improvised investigation.

Match help to the need

Routine support may include a trusted colleague, GP, occupational health, employee assistance, BMA counselling or a specialist practitioner service. Urgent distress requires same-day clinical assessment. Immediate danger to life or safety requires emergency services. A workplace dispute may need union or HR advice in addition to health care. A patient-safety concern may require incident reporting or speaking up.

Clarify service eligibility. Practitioner Health provides specialist confidential treatment for eligible health and care staff in England who cannot access care locally for confidentiality reasons; Canopi supports eligible NHS and social-care staff in Wales. Scotland and Northern Ireland have their own workforce routes. No single service covers every nation or every need.

Support without taking over

A colleague can listen, accompany, help make a call or cover a task, but should not become the sole clinician, therapist or case manager. Agree what contact will happen next. If the doctor declines non-urgent help, keep the door open and consider whether any professional duty still requires action. If safety is at stake, consent may not be the only consideration.

After the immediate conversation, follow up. The period after a complaint, investigation, sickness absence or return to work can remain high risk even when the person initially sounds relieved. Ask what practical adjustments, supervision or workload changes have actually been put in place.

Confidentiality in support conversations

Before detailed disclosure, explain your role, what you will record, who may see it and the limits of confidentiality. Casual reassurance that 'this is completely confidential' may be misleading where there is serious risk, safeguarding concern or a duty to protect patients. The BMA's peer-support information, for example, describes confidentiality alongside rare circumstances in which risk may require further action.

Share the minimum necessary information for the agreed purpose. Do not discuss the colleague informally with others, store identifiable accounts on personal devices or mix a supportive conversation with performance management. If you occupy two roles, say which role you are acting in and address conflicts early.

Worked example: a colleague who has changed

An experienced locally employed doctor who is normally sociable becomes quiet, repeatedly stays after the shift and reacts sharply to routine questions. A colleague does not diagnose burnout or assume misconduct. They arrange a private conversation, describe the changes, ask how the doctor is and check whether there is any immediate safety concern. The doctor discloses severe insomnia after receiving a complaint.

The colleague helps arrange same-day clinical advice, checks that the doctor can travel safely and asks the duty manager to review clinical cover without sharing unnecessary details. Later, with consent, they help the doctor identify union or defence support for the complaint. This keeps health, immediate clinical safety and case advice in distinct but coordinated routes.

Questions when you are concerned

Use direct, humane questions: What have you noticed yourself? Do you feel able to work safely today? Do you feel safe from harming yourself or someone else? Is there somebody you want contacted? What would make the next few hours safer? Which professional support can we contact together?

Do not demand the full story before helping. Record and share only what the immediate safety plan requires, and arrange a follow-up contact so responsibility does not disappear after the shift.

Common mistake

Avoid this	Waiting for visible collapse or a confirmed diagnosis misses the opportunity for early, proportionate help.

Pause and reflect

If a colleague asked whether you had noticed a change in them, what specific observations could you describe without judgement?

Takeaways

- Change from baseline is often more useful than a label.
- Ask directly about safety when concern is significant.
- Health care, workplace action and patient-safety escalation may need separate routes.

Knowledge check

Choose one best answer. These practice questions support reflection; they do not assess a real case or confer accreditation. Answer positions match the browser edition.

1. Which is the best basis for starting a wellbeing conversation?

A. A demand for disclosure

B. Rumours from colleagues

C. A diagnosis you have inferred

D. Specific observed changes and genuine concern

2. A colleague hints that life is not worth living. What should you do?

A. Wait until the next appraisal

B. Promise absolute secrecy

C. Ask clearly about immediate safety and connect them with urgent help

D. Avoid asking directly

3. An acutely impaired doctor is due to continue a clinical shift. What is the immediate priority?

A. Protect the rota

B. Start a disciplinary interview

C. Arrange safe cover and urgent assessment

D. Ask them to sign a statement

4. Which service provides every form of health, legal and employment support?

A. A SAS Advocate

B. No single service

C. Occupational health

D. A counsellor

5. What should a supportive colleague avoid?

A. Listening privately

B. Following up later

C. Becoming the only source of care and case management

D. Helping make a call

6. What should be explained before sensitive disclosure?

A. Role, records, access and limits of confidentiality

B. The likely diagnosis

C. Only the meeting length

D. That nothing will ever be shared

Answers and explanations

1. D — Specific observed changes and genuine concern

Specific observations are respectful and less likely to feel accusatory.

Review how change from baseline is used.

2. C — Ask clearly about immediate safety and connect them with urgent help

Clear, direct assessment and urgent help are appropriate when self-harm risk is suggested.

Revisit the section on direct questions and urgent help.

3. C — Arrange safe cover and urgent assessment

Patient safety and humane clinical support come before employment fact-finding.

Review the distinction between immediate safety and later process.

4. B — No single service

Different needs require different professional routes.

Review the service-matching explanation.

5. C — Becoming the only source of care and case management

Colleagues should support connection to appropriate professional care rather than carry the whole risk alone.

Review safe boundaries when helping a colleague.

6. A — Role, records, access and limits of confidentiality

Informed trust depends on realistic confidentiality expectations.

Review confidentiality and role boundaries.

Official and professional sources

Confirm the current source version and applicable nation, contract, scheme or specialty. A source list is not a statement that every rule applies to every reader.

Good medical practice 2024
UK · https://www.gmc-uk.org/cdn/documents/good-medical-practice-2024---english_pdf-102607294.pdf

BMA counselling and peer support
UK · https://www.bma.org.uk/doctorshealthmatters

NHS Practitioner Health eligibility
England · https://www.practitionerhealth.nhs.uk/healthcare-staff-in-england

Canopi: confidential support for NHS and social-care staff
Wales · https://canopi.nhs.wales/frequently-asked-questions/

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