Chapter 5: Addressing the challenges facing medical practice

The medical profession continues to deliver high-quality care across the UK. This is evident in the thousands of positive testimonies from patients and their families, the great strides in innovation and research, where we continue to be a global leader, and the high respect for the UK’s medical education and practice around the world.

At the same time, as this report shows, medicine is undergoing substantial change and faces many challenges. In all specialties, doctors are experiencing more demands, the nature of their practice is becoming more complex, and most are working in organisations under greater strain.

Understanding what is happening to the medical profession and the environment in which it has to operate is vital if we are all to identify the opportunities and risks facing medical practice. This report provides a perspective on this, although inevitably it is a partial one. It does, however, raise questions for the GMC, as we seek to develop a new model of regulation for doctors, leaders of the medical profession, educators and employers.
How does regulation need to change?

Three overarching themes are discernible. First, this is the age of data and intelligence, which will profoundly change the transparency of the healthcare system, the nature of transactions (above all with patients) and the capacity to understand and rank individual, team and institutional performance.

Second, the standards set for medical practice should be seen as contributing to part of a wider movement that puts safety and quality at the heart of the UK’s healthcare system, not as something distinct or separate.

Third, a national debate is developing about how the medical profession is to provide clarity about what is expected of doctors in this changing world. In particular, recent inquiries have highlighted the question of accountability – the fact that too often no one was taking responsibility for the overall care of highly vulnerable patients. The practice of medicine is not merely a technical skill or the prescription of a limited intervention. Doctors must ensure that they are responsible for their patient’s complete care and treatment and for the effective functioning of the healthcare organisation in which they are practising.

In the past year, there have been initiatives aimed at tackling accountability – the Mid Staffordshire inquiry called for a single clinician to take responsibility for each patient’s hospital care.1 In Wales, the NHS has also introduced a key worker to coordinate the clinical and non-clinical care of those diagnosed with cancer, in part to ensure that the care provided is holistic and patient centred.92 But more still needs to be done to clarify the responsibilities of doctors in this new environment.

What can we and others do to address the challenges raised in this report?

Among the issues in this report, four are worth highlighting for action by the GMC and others.

- The shape of the workforce has changed substantially over the past six years. We and others need to consider how this affects our ability to meet future healthcare demands.
- There is a rising tide of complaints about doctors and other healthcare professionals – the evidence suggests this is a reflection of a changing and more challenging world, not a reduction in standards. But the GMC and others need to understand more about the nature and source of complaints and the contexts in which these complaints arise.
- The risks of being complained about, being investigated by the GMC, or receiving a sanction or warning vary substantially between different groups of doctors. We need to better understand these patterns because they suggest that some doctors may need more support.
- Some of the data held by the GMC can provide insight into wider safety and quality issues. The fact that our data are associated with indicators of variation in the healthcare system, such as mortality rates, underlines how important it is for us to work with other organisations, sharing data and intelligence, to identify risks to patient safety.
The changing shape of the medical workforce

As discussed in chapter 1, the shape of the medical profession continues to change and grow, but not necessarily at the pace required to meet the changing demands for healthcare.

There are clear variations in the size and shape of the medical profession across the UK. Some parts of the UK have traditionally relied more heavily on international medical graduates, and now face the growing demand for healthcare with fewer of these doctors. So far, this decreasing supply has been matched by creating more places in UK medical schools – but the need for an adequate supply of medical graduates remains and we also need to make sure that UK graduates are attracted to the roles that need filling and in locations where there are vacancies.

The number of female doctors is continuing to increase and, in just a few years, there will be more female than male doctors. Although the rapid rise in the proportion of female doctors does now seem to be slowing, based on the profile of students entering medical school, the shape and character of the profession have now changed permanently.

While the work patterns of doctors are difficult to predict, and may well change, it is reasonable to assume that more doctors – both male and female – will choose to work part time in the decades to come. Some caution therefore is needed when predicting an oversupply of doctors. Historically, UK workforce planning has underestimated demand for doctors, training too few – not too many.

The Centre for Workforce Intelligence in England is forecasting an undersupply of GPs and an oversupply of other specialists. But this does not mean that the workforce is keeping up with the pattern of demand in hospitals – far from it. Certain specialties are continuing to struggle with recruiting doctors, including general practice, emergency medicine and psychiatric medicine.

Action

Greater flexibility in training and career paths is urgently required to design a workforce capable of meeting future healthcare needs. But this complex problem cannot be addressed by one organisation alone. Our analysis on the changing shape of the profession offers further insight for us, governments, workforce planners, and educators, who all have a part to play.

The independent Shape of Training review, which is due to publish its findings later this year, is considering these issues in the context of postgraduate training. But, as The King’s Fund highlights, most professionals who will be working in the NHS in ten years’ time are already working in the NHS. In this context, we must also focus on retraining and support for current professionals, as well as making sure that tomorrow’s doctors have the appropriate skills.

As part of the information required for revalidation, we will acquire a much better understanding of where doctors are working and in which settings. This should provide further insight into the nature and shape of the medical workforce across the UK.
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General Medical Council

Supporting complainants

As discussed in chapter 2, the rising number of complaints we receive about doctors is part of a wider picture of rising complaints about all healthcare professionals to the NHS, to other regulators and to ombudsmen. Never before has it been so important to understand these complaints and to do everything possible to make sure they are handled effectively and sympathetically. It is vital too to explore the pattern of complaints – we need to understand if there are common themes in who complains, what they complain about and what drives their complaints.

For the complaints received by the GMC, it would clearly be inappropriate for us to fully investigate every one – most could never result in us taking action on a doctor’s registration and are better dealt with locally. Nevertheless, as discussed in chapter 3, we have found that even past complaints that do not meet our threshold for investigation indicate an increased risk of investigation into a doctor’s medical practice in the future. The risk is still small but we need to reflect on this and discuss the implications.

We continue to see increases in complaints from members of the public, including patients and their relatives. We now have a better understanding of what type of complaints they are making and we are undertaking further research into what drives their complaints. The research is looking at a number of factors that might be driving this trend, such as the heightened profile of the GMC and other regulators, better access to information through the internet and social media, and easier ways to complain.

The fact that we are unable to take forward the vast majority of their concerns highlights the challenge that patients still face in navigating through the maze that is the complaints system in healthcare. It would be much simpler if most complainants felt they could have their complaint dealt with locally, and only need to take the matter to the GMC if they were dissatisfied with the outcome of that process.

Along with rising complaints from patients, we have seen a large increase in complaints from employers and doctors. We believe this is due to better clinical governance and to doctors and other healthcare professionals being more willing to raise concerns. As such, where the concerns reflect serious shortcomings in a doctor’s practice, it is something to be welcomed and encouraged. That said, we cannot be complacent and the evidence from the Mid Staffordshire inquiry and from our own confidential helpline suggests that more needs to be done to make sure doctors feel confident about raising concerns.

Action

One of the key lessons for the healthcare system over the past 18 months has been to recognise the importance of listening to patients and their relatives. The complaints system is complex and difficult to navigate and we and others need to do more locally and nationally to make sure that patients have appropriate channels through which to voice their concerns and have them addressed.
We are committed to playing our part in this. We will work with other organisations and the UK Government to simplify the process and direct complainants to where they can receive appropriate help. This year, for the first time, the GMC produced a guide for patients on what to expect from their doctor and this has proved popular among patient groups. We will build on this, working closely with patient and advocacy groups through our regional liaison service in England, and our offices in Northern Ireland, Scotland and Wales.

We also need to manage the increasing number of concerns from employers and doctors. Our employer liaison service has been extremely well received and we will evaluate its impact over the coming year. At the same time, we will continue to raise awareness that every doctor has a professional obligation to raise and act on concerns about patients’ safety and welfare, and that organisations need to change their culture to allow doctors to do so.

Variation in the risks of being complained about or receiving a sanction or warning from the GMC

There are clear associations between a doctor’s characteristics and area of practice and the chance that they will be complained about, investigated, or receive a sanction or warning from the GMC.

We recognise that the contribution our data can make to understanding risks of poor practice may be limited by the small proportion of doctors who are complained about and by the even smaller proportion who receive a sanction or warning. Furthermore, the circumstances leading to poor practice are complex and likely to involve several different individual and organisational factors.

But the fact remains that some groups of doctors are at greater risk than others and may need more support from us, their employer or their college or faculty. There will always be variations in practice, but we need to identify and, where possible, reduce the future risk of care falling short of what patients expect and deserve.

In chapter 3, we have identified that a doctor’s age, gender, and place of primary medical qualification all have a bearing on the likelihood of being complained about, investigated, or receiving a sanction or warning from the GMC. By analysing these characteristics together using data from several years, we can see that there are particular groups that face a significantly higher risk of falling below the standards expected.

Action

Recent and past inquiries into failings in healthcare show that many of the problems are systemic – the result of organisational and process design rather than individuals’ failings. The risk of a doctor performing poorly is influenced by the context in which they work – for example, how much pressure they are under, the organisation’s expectations, and the amount of support they get from others in the team. But this is only part of the picture.
We and others need to understand better which doctors are at greatest risk of poor performance and in need of additional support, and in which environments they are likely to struggle to deliver high standards of care. This, together with addressing the systemic factors, must form part of the move towards safer healthcare.

Again, this is not just a matter for the GMC. It needs to be part of a wider professional debate and it is important that employers, governments, and other regulators, as well as those who contract with doctors, understand the nature of the risks and take steps to monitor and support practice where risks are higher.

The challenge for the GMC is to move from a focus on investigating complaints, when things have gone wrong, towards making sure that there are systems to support doctors and help them overcome challenges, before such issues become a risk to patient safety.

The interaction between professional and system risks

Professional regulation does not exist in a vacuum – a doctor's ability to provide good medical practice is affected by the working practices and culture of the organisations they work in. However, what we have been less certain about, until this year, is how the data we hold about doctors relate to data about the environments in which they work.

Our findings in chapter 4 are only exploratory, but they do show that our fitness to practise and education data are associated with indicators of the well-being of acute NHS trusts in England. This relationship needs further exploration to see if it can contribute to models of risk in the healthcare sector.

It is clear from this report that there is still much we do not know about how the healthcare system affects the quality of medical practice and training. Our data were associated with a number of indicators of quality at a NHS trust but not with some other risks in the system.

Action

The Mid Staffordshire inquiry highlighted the importance of organisations working together and sharing data and intelligence about the quality of care. The findings in this year’s report indicate that sharing our data as part of working more closely with others could help identify risks to patient safety.

At the same time, at the GMC we need to understand better the data that we hold and consider the contribution that we can make to identifying and tackling the risks to healthcare services. As we continue to analyse fitness to practise data and the responses to our national training survey, alongside other external data sources, we should be able to identify trends at regional and at trust or board level.