

General
Medical
Council

The state of medical education and practice in the UK **2018**

Executive summary



Working with doctors Working for patients

Executive summary

In our eighth annual *The state of medical education and practice in the UK* report we set out the challenges in healthcare that continued throughout 2018.

We present important new primary data and analysis on the mindset and coping mechanisms of a medical profession working within a highly-pressured system. This will help our understanding of what is needed to support and retain the current workforce and supply of doctors for the future. The UK is running out of time to prevent a significant decline in workforce numbers, which risks patient safety.

A workforce strategy to make sure the progress of the past 70 years does not stall

The profession is at a critical juncture

Demand for care is increasing in volume and complexity. Combined with severe shortages of staff in some areas of the UK and in some parts of health and care provision, this creates huge pressures on the medical workforce.

Doctors are still delivering good care in very trying circumstances. Many are still positive and managing, but the stress is causing many doctors to consider future options that would reduce or end their clinical practice.

The health system now faces a decline in what can be offered and how it is offered by doctors who are prioritising and compromising their work in an effort to maintain standards of care for their patients. It shows that doctors are reaching the limit of what can be done.

Our new evidence reveals the effect of these pressures and the steps doctors are taking to cope. We are concerned that some of these strategies are risky or unsustainable.

We are saying loud and clear: the medical profession is at the brink of a breaking point in trying to maintain standards and deliver good patient care.

New evidence shows how doctors on the frontline are experiencing current pressures

We have commissioned two pieces of independent research. The first, *Adapting, coping, compromising*,* looks at how doctors are having to adapt their practice, the coping mechanisms they are adopting, and the compromises they are forced to make – and what this means for patients as well as doctors.¹

* For further details of *Adapting, coping, compromising* and *What it means to be a doctor* see research and data notes in the full report.

Our second piece of research, *What it means to be a doctor*, attempts to understand the essence of being a doctor and how they experience their role in 2018.²

Our intelligence from frontline engagement with doctors has already been picking up the multiple signs of a profession under pressure. Doctors feel less supported and more vulnerable than ever, working in a system under such intense pressure. This is not sustainable and changes must be made.

What we are concerned about

Burnout and poor mental health

We are worried about the effect of pressures on doctors who suffer stress, ill health and particularly mental health issues exacerbated by the pressures they encounter. We are working on several aspects of this including commissioning an independent review of doctors' wellbeing.

Urgent steps are required to retain doctors

Our commissioned independent survey of 2,602 doctors shows that almost two thirds are working more hours than in the past, but often with less time to provide continuity of care for patients.²

We are at high risk of doctors leaving clinical practice in unprecedented numbers. Within the next three years, many are considering reducing their hours (around a third), going part time (a fifth) and/or planning to leave UK practice and work abroad (a fifth).²

Encouraging a new supply of doctors

There is a need to increase the supply of new doctors to cover these shortages. We welcome the addition of five new medical schools in England³ and additional medical school places in Scotland⁴ and Wales.⁵ Given the urgent need to increase supply, we are planning a rigorous programme of visits and scrutiny to help these new schools meet the same existing high standards as current ones.

Implication of Brexit on the workforce

Continued uncertainty over Brexit adds to the risk of us and others being unable to plan in a way that enables a sufficient future supply of doctors. It is essential that exiting the EU does not either deliberately or inadvertently deter the approximately 2,000 EEA qualified doctors who come here each year and contribute to the NHS.

Call to action

The pressures continue to mount and doctors' intentions to leave or reduce clinical practice threaten further decline in the supply of doctors.

The severe pressures are already affecting services, training environments and the ability of doctors to do their jobs. Significant numbers of doctors are reporting burnout in the face of these pressures. Many have already reduced their hours to cope with the stress of these pressures.⁶

We are adopting approaches to support doctors under pressure and to make the processes involved in joining the register as streamlined as possible to encourage the supply of new doctors. But we can't work alone – there are implications for everyone involved in the UK health system.

What is needed now?

- The UK health system needs long-term planning to make sure that the healthcare sector has a workforce with the right skills in the right places. Without the right support, doctors will come under even greater pressure and the situation may deteriorate.
- The healthcare sector needs action. Not just more money, but a commitment to new ways of thinking about how workforce supply can be achieved. And how that workforce can be enabled to achieve the professional standards and consequent quality of care that should be expected 70 years on from the founding of the NHS.
- There are particular opportunities to act now. We have particular opportunities to achieve this with new investment in the NHS in England, new workforce strategies in Scotland and England, and ongoing workforce planning across the UK. Strategies in all four countries of the UK need to set out a clear plan for making the UK a great place to work for doctors and a world-leading healthcare environment that attracts, develops and retains the best doctors and provides fantastic patient care. As well as setting a compelling vision for the next ten years, these strategies must also address clear and present dangers, such as the potential cliff edge of a no-deal Brexit and some of the workplace culture issues.

Supply – the medical workforce

We look at the make-up of the 242,433 licensed doctors and how trends have differed across primary and specialist care and between the countries of the UK.

We examine the pool of doctors available to the workforce – the net effect of those joining and those leaving. We highlight the specialisms and localities where there is the risk that the UK may not have the supply of doctors needed to meet growing demand.

There are positive signs that the shape of the workforce is improving. But much still needs to be done to make sure there are enough practising doctors to meet the UK's needs.

Doctors joining the profession

Licensed doctors

We are seeing an increasing pool of doctors potentially available for the workforce, with the number of licensed doctors on the medical register and students studying medicine rising. And we see signs that gaps in the workforce for GPs are being improved through the increase in doctors training in general practice.

The number of licensed doctors on the medical register is now increasing. As the effect of introducing revalidation has stabilised, we are seeing a rise in doctor numbers larger than the growth in the UK population, with a 2.0% growth in licensed doctors in 2016–17, and 2.4% in 2017–18.

Number of licensed EEA graduate doctors remains steady

From 2014–16, the number of EEA licensed doctors dropped by 9%. This was probably due to the introduction in June 2014 of a requirement to show proof of their English language capability before they gain a licence to practise. Since then, the number of licensed EEA doctors has increased slightly each year, rising by 0.3% in 2016–17, and by 0.8% in 2017–18.

We have no evidence of an overall decrease in EEA doctors since the outcome of the June 2016 referendum to leave the European Union.

Number of GPs continues to grow, but at a slower rate than specialists

The GP Register has grown by 4% in the period 2012–18, compared with the Specialist Register, which has grown by 11%. This is significant given the shortages of GPs generally and the fact that so many GPs intend to retire or go part time.

The growth in GPs is primarily driven by numbers in England, where the number of GPs by grew 6.8%. Northern Ireland and Scotland showed very small increases, while Wales showed a decrease.

Welcome increase in emergency medicine, but decline in psychiatry worrying

There is a considerable difference in growth in the pool of available doctors between specialties. There has been a very strong growth of a third in emergency medicine doctors since 2012, but reports suggest this has not been sufficient to alleviate pressures in emergency departments.^{7, 8, 9}

As last year, our most up-to-date figures re-emphasise that the number of psychiatry specialists on the medical register is decreasing.

Occupational medicine and public health are both reducing in terms of the number of specialists.

Supply of new doctors from outside the UK

Half of doctors new to the UK are non-UK graduates

Medical graduates from outside the UK continue to be a source of doctors coming into the UK workforce. In 2017–18, half of new joiners were non-UK graduates, up from 44% in 2012.

Increase in doctors joining from Central and Eastern Europe and the Baltic countries relative to the rest of the EEA

This year we see a continued slight increase in doctors from EEA central, eastern, and Baltic countries on the medical register. The numbers from other EEA regions has continued to decrease, with a notable 20% reduction since 2012 in the number coming from the northwest of Europe.

Declining number of doctors joining from North America and Australia

The number of doctors joining from North America has declined by a fifth since 2012. And those joining from Oceania – which includes Australia – has reduced by over a third (35.8%); the largest relative decline from any region.

Supply of new doctors from within the UK

In 2017 the number of medical students in the UK passed the 40,000 mark, rising to 40,997. The enduring popularity of medicine as a degree is encouraging and reassuring, particularly because it comes amid a dip in the general population of UK 18-year-olds, which provides a significant proportion of the new medical students each year.¹⁰

The number of doctors entering training in general practice is up by more than 10% since 2012, compared with a 1% increase in doctors in training overall, which is welcome given the shortages to the UK workforce. The number of doctors entering training in emergency medicine also increased, by 144% to 1,520 over the period from 2012–18.

However, psychiatry – a specialism reducing in number overall, but with growing demand – is down the most by almost 12% in the number of doctors in training choosing it. This highlights the need to source these doctors from outside the UK – in the short term at least.

Doctors leaving the UK profession for at least one year

Almost 4% of licensed doctors – 9,314 doctors – left the profession for at least one year in 2017.

Younger UK graduate and international medical graduate doctors are increasingly leaving the profession, primarily to go abroad

The number of doctors leaving the profession varies between those of different ages and between those whose primary medical

qualifications are from the UK, EEA and elsewhere. Among UK and international medical graduate doctors, the number and proportion of doctors leaving who are under 30 years old was considerably higher in 2017 than in 2012. Younger doctors are most likely to be moving overseas, potentially to work abroad, and so may return to UK practice.

Evidence of doctors changing their work patterns in response to pressures

Both of the primary research studies we commissioned for this year's report have shown that many doctors have made, or are considering making, changes to their working patterns including leaving or reducing their hours.

Out of 700 doctors surveyed, around one out of four reduced their hours over the past two years as a direct result of the pressure they were under.⁶

A third considering leaving clinical practice in the next three years

A third of doctors are considering as their main career change one or more courses of action in the next three years, which would result in them no longer working in clinical patient-facing roles.²

Urgent action is needed to make sure doctors are supported so they don't leave just because the pressures on the system make their role as a doctor feel untenable.

Supporting doctors working under pressure

We look at the realities of doctors' experience of training and working in a system under pressure, some of the strategies and coping mechanisms they are adopting, the concerns we have at how sustainable some of these are, and the support doctors tell us they need.

Our new research from *What it means to be a doctor* and *Adapting, coping, compromising* demonstrates how the strategies that doctors are forced to adopt are unsustainable – not only because of the effect on them personally, but also because they are potentially increasing patient care demand in the future.^{1,2,6}

The evidence gathered shows that the pressure and heavy workloads doctors report experiencing are presenting risks to standards in patient safety and slips in the quality of care. The evidence is very concerning and demonstrates the urgent need to relieve the pressure our medical workforce is under.

Types and sources of pressure

There is evidence from a range of sources showing that pressures on doctors are continuing to build.

External pressures:¹ In interviews, doctors raised a range of external factors that cause them to feel pressured and to ask themselves whether they will be able to do their job with the limited time and resources available. These included:

- increasing number of patients, particularly those with co-morbidities

- specific time periods of high demand and/or shortage of experienced staff
- the overall system, including targets and administrative requirements.

Of these, a shortage of experienced staff is the most cited source of pressure by doctors, there being too few doctors with the right level of experience and skills.

Internal pressures:¹ Doctors are also subject to internal pressures – whether they believe they will be able to do their job well. Doctors' own feelings of responsibility lead them to take on more work than they can strictly manage; they know they will put themselves under pressure, but feel an obligation to patients and colleagues. Over two thirds reported that they are working beyond their rostered hours at least once a week.²

Longer hours but less continuity of care

Three out of five doctors (63%) said the time they spend working has increased over the past three years. And only 13% said they now spend less time working.²

This is in stark contrast with feelings around continuity of patient care: 44% of doctors said that opportunities to offer continuity of care have decreased, with just 15% saying they have increased.² Doctors are working longer, but are less able to provide continuity of care in the face of increased work and system pressure.

Deterioration of work-life balance

Doctors also found themselves catching up on work or training in their free time or on annual leave. Though these strategies were not adopted willingly, doctors felt that sometimes they were the only available options.

The majority of surveyed doctors* (60%) reported that their satisfaction with their work-life balance has deteriorated (either somewhat or significantly) in the past two years. Over a fifth of these doctors (22%) reported that it has deteriorated significantly.⁶

This deterioration is most pronounced for GPs, and is worst among younger GPs. Around three quarters of younger GPs surveyed (72%) said their work-life balance has deteriorated.⁶

Impacts of the pressure

Pressures are making it difficult for doctors to support each other

- Three out of ten felt unsupported by management or senior colleagues at least once a week, and one out of eight felt unsupported by immediate colleagues at least once a week.²
- Three out of ten said mentoring provided to them has decreased and nearly half said the time available to reflect on their practice has decreased.²
- Just under a quarter of doctors (23%) felt unsupported by immediate colleagues at least once a month.²

Taking leave of absence and considering leaving the profession

- One out of four doctors said they have considered leaving the medical profession at least every month.²
- Two out of every 100 doctors said they had to take a leave of absence due to stress at least once a month over the last year. This rises to four out of every 100 doctors on neither the GP nor the Specialist Register and not in training.²

Strategies to deal with pressures

The research findings suggest that there are four ways that doctors are dealing with these pressures. We have a number of concerns about the limitations and impacts of these strategies.

- 1 **Using smarter ways of working to manage workloads**, such as telephone consultations, and accessing test results and imaging online. While many developments in this area are seen as positive, there is a sense for many that the limits of smarter working have been reached.^{1,6}
- 2 **Prioritising certain aspects of clinical service and patient care at the expense of other activities**. Often this means withdrawal from continuing professional development (CPD), less time spent reflecting and a drop in attendance at activities that are important for the overall health system to operate efficiently and safely in the longer term.^{1,6}

* 700 doctors were surveyed in the *Adapting, coping, compromising* research project (reference 6 only). See the data notes in the full report for more information.

3 Changing the type of work doctors do such as working outside their grade or level, with doctors 'acting up' or 'acting down' becoming normalised and changing how they work with colleagues and patients.^{1,6}

4 Adopting strategies that prioritise immediate patient care and safety, including making unnecessary referrals.

These appear to be applied when previous coping mechanisms have been exhausted. Doctors have to move patients on to reduce their own workloads, so they are not spending sufficient time with them and are bypassing the use of clinical checklists and protocols.^{1,6}

Personal coping mechanisms

Many doctors discussed reducing their hours and taking retirement earlier. But there were other less-dramatic solutions. These include pushing back when they felt the demands being made on them were unreasonable.^{1,6} Nearly two fifths of surveyed doctors said they had refused to do additional work over the past two years as a result of pressure on workload and capacity.⁶

Pressures are felt differently among the profession

The extent of the pressures, the way they are felt by individuals and the degree to which the various strategies and coping mechanisms are adopted vary from place to place and doctor to doctor.¹

Despite most doctors being exposed to at least some of the pressures and negative effects of some of the coping strategies they are forced to adopt, two thirds remain at least somewhat satisfied.²

- There needs to be more learning about some of the factors that may contribute to this satisfaction in some places despite the pressures.
- Even so, one out of four doctors said they are at least somewhat dissatisfied.²

Support

Resources are required to reduce doctors' need for strategies that compromise patient care and safety, that prevent doctors from supporting each other and developing professionally, and store up problems for the health system in the long term.

Our response must also involve creative ways to directly address the areas doctors have told us would support them.

Some of the areas doctors have said they would like more support around include:^{1,2,6}

- support and mentoring from colleagues and senior management
- prioritisation of mental and physical health
- implementation of work-based support systems
- promotion and protection of continuing professional development (CPD) and other non-clinical activities.

A quality workforce: ensuring standards, applying fairness

The provision of a quality workforce needs to be a collective action by all in the health system. In this chapter we examine the measures we are taking to make sure high standards are maintained, and to relieve the burdens doctors are facing in modern clinical medicine. It looks at how we support all groups of doctors to achieve high standards throughout all stages of their career, and particularly how they can realise their potential during training.

This chapter also provides our latest data on fitness to practise, and gives an update on the reforms we are making to make these procedures fair.

Ensuring standards

Enhanced monitoring

When postgraduate bodies are concerned about the training of doctors, they work directly with trusts and health boards to make improvements.

If the situation doesn't improve, they tell us. We also receive reports from the medical royal colleges, faculties, and others if they have concerns, so we can see evidence of pressures building from different sources.

We then work with all the organisations involved to address the concern, improve the quality of training, and develop a sustainable solution through our enhanced monitoring process.

Feedback from those we work with tells us that enhanced monitoring is effective. We know

that direct GMC involvement raises the profile of education issues. It also means that local education providers will dedicate resources to education and training. This is important for influencing longer-term cultural change at struggling organisations. It also makes sure education is given appropriate weight.

Enabling all groups to reach their potential

Our standards require training pathways to be fair for all. We have worked to support groups of doctors who have different achievement levels from others, known as differential attainment.

- We hold organisations to account through capacity building and building the evidence base on differential attainment. We have strengthened our regulatory monitoring of how organisations responsible for the design and delivery of medical education are responding to the differentials as required by our standards. We have asked each local office for Health Education England, NHS Education for Scotland (NES), Health Education and Innovation Wales and Northern Ireland Medical and Dental Training Agency, and the medical royal colleges to describe how they are responding to the attainment gap.
- We have published a toolkit, which gives practical ideas on how organisations can evaluate the impact of their activities. And we run a national forum, through which they can share their learning with others across regional and specialty boundaries.

A common threshold for safe practice

We are developing plans to establish a Medical Licensing Assessment (MLA), which builds on our existing assurance work by setting a common threshold for safe practice for UK medical graduates and international medical graduate doctors.

New guidance on reflective practice

We co-produced and published new guidance on reflective practice in September this year – *The reflective practitioner*,¹¹ working with the Academy of Medical Royal Colleges (AoMRC), the Conference of Postgraduate Medical Deans (COPMeD) and the Medical Schools Council.

The new guidance was in answer to calls from medical students, doctors, responsible officers and appraisers for clearer information on what is meant by reflection and how it can be used within medical practice. The short guide illustrates commitment to supporting an open and honest learning culture and offers clarity in a number of areas.

Fairness in fitness to practise

Fitness to practise and reforms in this area

The complaints we receive about doctors continue to reduce. Last year we saw that the decline in complaints had slowed but in 2017 the downward trend continued, with a year-on-year reduction of 8%.

Success of provisional enquiries

In 2017, 40% of complaints that weren't closed immediately or referred back to the employer

are now subject to provisional enquiries. Of these, 68% have not subsequently required a full investigation.

Since being introduced, 951 complaints have been closed after provisional enquiries, reducing considerably the burden on the doctors concerned, compared with what would have been the case had they been subject to a full GMC investigation.

Local first

We want to make sure concerns are dealt with as swiftly and efficiently as possible for everyone involved. We have come a long way, but there is still much more we want to do.

Our long-term aim (requiring legislative reform) is that all complaints and concerns about doctors should be dealt with at the right level and, where appropriate, concerns should be addressed locally, only involving GMC action where necessary.

We are committed to a pilot of a local first approach by 2020. We are doing research to help us understand how this would work, how we can work with others to partially achieve this ambition within current legislation, and where legislative reform is most important.

Fairness

We take our responsibility to be a fair and transparent regulator very seriously.

We know there is disproportionality in the flow of complaints into the GMC and that some groups are more prone to complaints or concerns from particular sources, such as the police or employers, compared with others.

Research has not yet established deeper reasons behind why certain groups of doctors are referred more often. We have commissioned independent research to better understand the referral of doctors by employers, led by Roger Kline and Dr Doyin Atewologun.¹²

Supporting doctors to uphold standards

Raising concerns

There have been reports from our Regional Liaison Service that there is an issue with the processes of reporting and acting on concerns about patient safety. And that doctors are 'inoculated' against problems linked to resource shortages, in the sense that they have become 'normal ways of operating' so may not be reporting those concerns as a result.

Trainees' concerns about patient safety and education

There is a largely positive picture about the reporting of patient safety and educational concerns by trainee doctors, but not uniformly. Our national training survey¹³ findings show substantial minorities of trainees do not feel confident about raising concerns, nor do they feel that any concerns raised will be dealt with appropriately.

- Four out of five trainees say there is a culture of proactively reporting concerns in their post, while 3.8% disagreed or strongly disagreed that there was a culture of reporting concerns.
- GP trainees were more likely to say there is a culture of proactively reporting concerns than surgical or medicine trainees.
- A quarter of trainees do not think patient safety concerns are adequately dealt with, which is potentially worrying.
- One out of ten trainees are not confident that their concern would be addressed. Only two thirds are confident.

We are committed to playing our part in engendering a speak-up culture in the healthcare sector. We have a pivotal role to play in making the health service a place for learning, not blaming.

We are one of nine health and social care regulators in England which have signed a new agreement to more effectively share concerns that may indicate current or future risks to users of services, their carers, families or professionals.

How we and others can build a sustainable workforce

Looking at the bigger picture, we examine what could be done if there were the wider will for bold change, and if other stakeholders agreed that such action, individually and in collaboration, is the way forward. We identify things that we and others could do if there were general support from stakeholders.

Improving the supply of doctors

There are lots of ways to improve the supply of doctors to the workforce. In this chapter we consider some approaches we could particularly contribute to, alongside others. And we outline some of the activities that we are doing, often in partnership with others to achieve this.

We have been working with NHS England (NHSE), HEE and the Royal College of General Practitioners (RCGP) to support the international GP recruitment programme. We have also supported NHSE to proactively contact overseas doctors currently training in the UK to encourage them to consider primary care for their specialty training and remain in the UK to work following completion of their certificate of completion of training (CCT).

The numbers of international medical graduate doctors seeking to sit the Professional and Linguistic Assessments Board (PLAB) assessment test has increased significantly in the past 12 months. To support this demand we have run more PLAB 2 testing days than ever before. In summer 2019 we will also open a new two-circuit clinical assessment centre in Manchester for the PLAB 2 assessment, which will reduce waiting times and support doctors to obtain

registration more quickly. We have also provided our first PLAB 1 assessments in Scotland.

The introduction of the MLA from 2022 means that UK medical students and international medical graduates will have to demonstrate that they meet a common threshold for safe practice in the UK before we register and license them. This will give greater assurance to patients, employers and educators that doctors entering the UK workplace have the knowledge and clinical and professional skills for safe practice.

Better support to retain and attract doctors

We have started a UK-wide review of medical students and doctors' wellbeing, led by Professor Michael West and Dame Denise Coia. This review will identify factors that affect the wellbeing of medical students and doctors, across the four countries of the UK. This work will be published in 2019.

We are also reviewing our quality assurance processes in education and training. And we will continue to support postgraduate bodies in their work with local education providers who are in enhanced monitoring.

We are engaging on a draft framework for credentials, which we plan to launch in 2019. This will address areas that are not already regulated and enable greater flexibility to meet patient and service needs and the career aspirations of doctors. And it will recognise the experience and knowledge that have previously gone unrecognised.

Supporting doctors who are not on the GP Register or the Specialist Register and not in training is an ongoing aspect of our work. We will survey doctors on neither register and not in training in 2019 to get a better understanding of their motivations, experiences and challenges. This will help us identify the best ways to support and develop this group of doctors.

Taking a more systemic approach to maintaining and improving standards

We recognise that no single organisation can successfully act alone to reduce the pressures that threaten medical standards or develop the most optimal framework for understanding risk.

A coordinated approach is necessary involving governments, arm's-length bodies, professional regulators, regional leaders, providers, patients and the public, and, of course, the professions

References

- 1 Community Research (forthcoming) *Adapting, coping, compromising: qualitative report* available at www.gmc-uk.org/somep2018
- 2 ComRes (2018) *What it means to be a doctor: survey findings exerts* available at www.gmc-uk.org/somep2018
- 3 The BMJ (2018) *Five new medical schools are created in England in a bid to increase home grown doctors* available at https://www.bmj.com/content/360/bmj.k1328?ijkey=8aed010420b810aaf77db6c8a53396b3f7b7cda9&keytype=tf_ipsecsha (accessed 9 November 2018)
- 4 Scottish Government (2018) *Record number of student medical places* available at <https://news.gov.scot/news/record-number-of-student-medical-places> (accessed 29 November 2018)
- 5 Swansea University (2018) *Expansion of medical education in Wales* available at <https://www.swansea.ac.uk/press-office/news-archive/2018/expansionofmedicaleducationinwales.php> (accessed 29 November 2018)
- 6 medeconnect (2018) *Adapting, coping, compromising: survey findings* available at www.gmc-uk.org/somep2018
- 7 Royal College of Emergency Medicine (2018) *Intense pressure facing our emergency departments* available at https://www.rcem.ac.uk/RCEM/News/News_2018/Intense_pressures_facing_our_Emergency_Departments.aspx (accessed 7 November 2018)
- 8 The King's Fund (2018) *A&E performance reaches a new low* available at <https://www.kingsfund.org.uk/blog/2018/01/ae-performance-reaches-new-low> (accessed 7 November 2018)
- 9 NHS Providers (2018) *Winter pressures in the NHS* available at <https://nhsproviders.org/media/4190/opposition-day-debate-winter-pressures-jan-18.pdf> (accessed 7 November 2018)
- 10 Higher Education Funding Council for England (2015) *Higher education in England: key facts* available at http://webarchive.nationalarchives.gov.uk/20180322112445tf/http://www.hefce.ac.uk/media/HEFCE,2014/Content/Analysis/HE,in,England/HE_in_England_2015.pdf (accessed 8 November 2018)
- 11 General Medical Council (2018) *The reflective practitioner* available at <https://www.gmc-uk.org/-/media/education/downloads/guidance/the-reflective-practioner-guidance.pdf> (accessed 8 November 2018)
- 12 General Medical Council (2018) *GMC commissions new research into fitness to practise referrals* available at <https://www.gmc-uk.org/news/media-centre/media-centre-archive/gmc-commissions-new-research-into-fitness-to-practise-referrals> (accessed 8 November 2018)
- 13 General Medical Council (2018) *National training survey 2018* available at <https://www.gmc-uk.org/education/how-we-quality-assure/national-training-surveys> (accessed 8 November 2018)

Email: gmc@gmc-uk.org

Website: www.gmc-uk.org

Telephone: 0161 923 6602

