

Executive summary

This is the fifth annual report on the state of medical education and practice in the UK. It focuses on what recent data and analysis can contribute our understanding of the challenges and risks that the medical profession faces.

The UK medical profession is rightly held in high esteem worldwide. Concerns about professional standards relate to a small minority of doctors. Nevertheless, the ambition must be both to improve standards generally and, as far as possible, to understand and remove any risks to the safety of patients.

This report includes:

- discussions about the subjects doctors seek further guidance on to prevent breaching standards
- an examination of the relationship between the places where doctors work and their professional standards

- attainment in medical education
- an examination of the types of case in which there has been a severe breach of standards requiring the suspension or removal of the doctor's licence to practise
- a study of the obstacles to the remediation of poor standards.

Along with this year's report, we have also published an extensive online resource of the GMC's registration, education and fitness to practise data. This contains more than 1,000 tables, set out in a structure designed to make it easy to find key figures. We hope that patient groups, employers, doctors, workforce planners, policymakers, researchers and regulators find this resource useful, together with the analysis in this year's report.

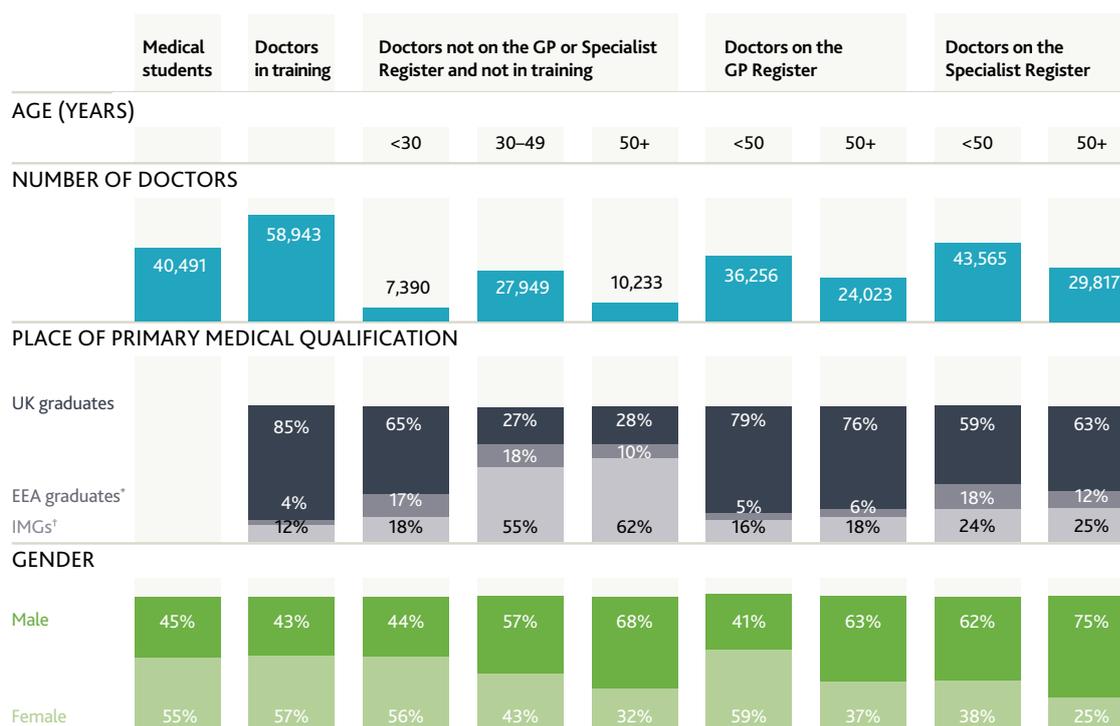
Our data on doctors working and training in the UK (Chapter one)

In 2014, there were 267,168 doctors on the UK medical register, 236,908 of whom had a licence to practise in the UK. Figure 3 (page 31) sets out the size of the medical workforce and some characteristics of licensed doctors and medical students in the UK. As previously reported, the proportion of female doctors continues to increase: in 2014 female doctors make up just over 50% of the GP Register for the first time.

We have identified areas of concern in the make-up of the profession in some specialties, which could have an impact in the future.

- A high, or increasing, reliance on older doctors.
- A high, or increasing, reliance on non-UK graduates.

Figure 1: Demographic characteristics of licensed doctors on the register and medical students in 2014



* EEA graduates are doctors who gained their primary medical qualification in the EEA, but outside the UK, and who are EEA nationals or have European Community rights to be treated as EEA nationals.

† IMGs are doctors who gained their primary medical qualification outside the UK, EEA and Switzerland and who do not have European Community rights to work in the UK.

A growing number of licensed doctors

The medical register continues to grow – since 2010, the number of registered doctors has grown by 12%. The number of licensed doctors has grown a little more slowly, by 4.5%, coinciding in part with the introduction of revalidation that encouraged some to choose not to continue to hold a licence to practise.

The number of doctors from southern Europe is increasing

The number of doctors from countries with high unemployment rates – such as Greece, Italy, Portugal and Spain – has increased by almost 2,107 during 2011–13, an increase of 36%.

Fewer doctors from many other parts of the world are taking up a UK licence to practise, and more are giving them up. The largest decrease in doctors on the register was among those who graduated in South Africa and India.

Pathology, intensive care and surgery rely on older doctors

Some specialty groups have an increasing proportion of older doctors – including intensive care and surgery. Pathology relies heavily on older doctors, and that specialty may risk not being replenished with younger doctors.

Some specialties are particularly reliant on non-UK graduates

Certain specialties rely more heavily on non-UK graduates, who are increasingly giving up their UK licence to practise, either to retire or to work abroad. In 2014, the majority of doctors in the obstetrics and gynaecology specialty were non-UK graduates, as were almost half of ophthalmology doctors.

Compared with the rest of the register, medicine, psychiatry, paediatrics, pathology, ophthalmology and emergency medicine saw substantially greater increases in the number of non-UK graduates during 2010–14. These specialties might be more at risk of doctors retiring or leaving in the future.

Complaints to the GMC about doctors (Chapter two)

Chapter 2 analyses complaints that were made to the GMC about doctors. The analysis focuses on two areas.

- The outcomes from different types of complaint.
- Who is making complaints and what sort of complaints they make.

Figure 2: Proportion of male and female doctors who were complained about, had the complaint investigated and received a sanction or a warning during 2012–14

	Doctors in training	Doctors not on the GP or Specialist Register and not in training			Doctors on the GP Register		Doctors on the Specialist Register	
AGE (YEARS)		<30	30–49	50+	<50	50+	<50	50+
MALE DOCTORS COMPLAINED ABOUT								
Not complained about	98%	96%	94%	90%	86%	80%	91%	86%
Complained about	2%	4%	6%	10%	14%	20%	9%	14%
RESULT OF COMPLAINT								
Closed immediately or referred back to employer	45%	35%	36%	46%	68%	65%	63%	64%
Investigated then closed without a sanction or a warning	44%	48%	52%	47%	29%	32%	33%	33%
Investigated then closed with a sanction or a warning	11%	17%	12%	7%	3%	3%	3%	3%
FEMALE DOCTORS COMPLAINED ABOUT								
Not complained about	98%	98%	97%	95%	93%	88%	95%	92%
Complained about	2%	2%	3%	5%	7%	12%	5%	8%
RESULT OF COMPLAINT								
Closed immediately or referred back to employer	57%	43%	44%	48%	74%	70%	68%	72%
Investigated then closed without a sanction or a warning	36%	44%	43%	47%	25%	28%	29%	27%
Investigated then closed with a sanction or a warning	7%	13%	14%	5%	2%	2%	3%	1%

The number of concerns raised by doctors has doubled in four years

The number of complaints that doctors (not acting on behalf of their employer) made about doctors nearly doubled from 654 in 2010 to 1,277 in 2014.

Unsurprisingly, most complaints still come from members of the public – the number increased from 3,858 in 2010 to 5,808 in 2014. Overall, the total number of complaints rose by 54% over the four years to 2014, but the increase slowed sharply in 2013 and 2014, increasing by only 5% in 2013, and falling by 2% in 2014.

The number of complaints closed with no action has increased much faster than the number resulting in a sanction

The number of complaints closed with no further action more than doubled between 2010 and 2014. In contrast to the number of complaints closed without a sanction, the number of sanctions decreased by 7% from 512 in 2010 to 479 in 2014. Some of these trends are driven by changes in how the GMC handles complaints, and some are informing the GMC's ongoing programme of reform to improve fitness to practise processes.

Hardly any investigations of clinical competence stemming from complaints by the public lead to a sanction or a warning

Nearly a third (31%) of cases from complaints made by members of the public are solely about the clinical competence of doctors. But 92% of these result in no sanction or warning, in part because in these cases it is more likely that a doctor can prove remediation and demonstrate insight in their cases.

Men face more investigations than women

Men are significantly more likely to face investigations than women, especially in criminality cases. Overall, 75% of investigations were about men and 82% of criminality investigations were against men.

BME and non-UK doctors are overrepresented in investigations

Between 2010 and 2014, a higher proportion of doctors who graduated outside the UK were subject to GMC investigations (59 per 1,000 doctors) than was the case for UK graduates (38 per 1,000 doctors).

Because doctors from a black and ethnic minority (BME) background account for a high proportion of non-UK doctors (66%), this also translates into a higher proportion of BME doctors being subject to GMC investigations in this period (55 per 1,000 doctors). BME doctors who were UK graduates were subject to a slightly higher proportion of GMC investigations than white UK graduates (41 per 1,000 doctors compared with 35 per 1,000).

Employers and others acting in a public capacity were more likely than individual doctors or the public to refer non-UK graduates. 63% of investigations stemming from concerns raised by employers and 52% of those stemming from others acting in a public capacity were about non-UK graduates. This compares with only 38% of investigations arising from concerns raised by doctors and 38% of those arising from complaints made by the public. This pattern was evident for all types of concerns and complaints, apart from ones about a doctor's health.

Issues linked to professional standards (Chapter three)

This chapter gives an analysis of education data and feedback received from medical educators, and from front-line doctors engaging with GMC liaison teams and contacting the confidential helpline. It also examines the fitness to practise cases that led to the doctor being suspended or removed from the register.

Medical educators raise a number of concerns with the GMC

Medical royal colleges and faculties submit an annual report to the GMC about their specialities, which gives an important insight into how different branches of the profession are managing – particularly in terms of education and training. This year, the reports highlight a number of concerns including concerns that the transfer of services to the independent sector is affecting training quality, and that difficulties filling posts is affecting the training quality of junior doctors.

Hospitals and other health providers that are subject to enhanced monitoring of their undergraduate and postgraduate training

During 2014, training environments in 28 NHS bodies were placed under enhanced monitoring. The most commonly reported concerns focused on poor access to education and problems with clinical supervision both on weekdays and at nights and weekends. In three of the trusts under enhanced monitoring, allegations of bullying or undermining of doctors in training were serious enough to require direct GMC intervention.

Areas where doctors are seeking advice to maintain standards

There are certain issues where doctors are coming forward to enquire about aspects of their practice. The principal areas are prescribing, confidentiality, the impact of new technology, and end of life care.

It is possible that these areas may be of more widespread concern within the profession and that there is a need to raise the profile of the issue or consider more guidance.

The most serious breaches of standards involve dishonesty, inappropriate relationships at work and inappropriate personal behaviour

A small study for this year's report looked at fitness to practise investigations that resulted in the most serious sanctions – suspension or removal from the medical register.

The study found that about half of these cases were predominantly about dishonesty, in one form or another. Sometimes, there was also a criminal conviction. Other themes include inappropriate behaviour and relationships both with patients and in the workplace.

GMC data and the performance of an organisation: a case study on acute trusts in England (Chapter four)

This study of acute trusts in England looked at whether the risk of a doctor at the trust being involved in a GMC investigation or the views of doctors in training in the GMC annual National Training Survey were in any way related to a trust being put into special measures or to the ratings given by the Care Quality Commission (CQC) to that trust.

The overall rating given by the CQC to providers is often worse when trusts have more doctors going through a fitness to practise investigation. The CQC operates a four-point scale from inadequate through to outstanding. There are around ten additional investigations per 1,000 doctors for each step down the rating scale, with those rated inadequate therefore likely to have 40 more investigations per 1,000 doctors than those rated as outstanding.

Hospital trusts in special measures have more fitness to practise complaints, but this may simply indicate heightened vigilance. The vast majority of this increase comes from institutional referrals within the trust. Interestingly, it does not lead to corresponding levels of sanctions and warnings, suggesting the increased vigilance in terms of referrals to the GMC may not in practice reflect more doctors in serious difficulty.

The study shows that there is a comparative increase in fitness to practise complaints and investigations in acute trusts in England one to two years before they were put into special measures. There is also a fall in complaints in the year after. It is important to note, however, that there is wide variety between individual trusts in the year they go into special measures and subsequent years. A trust going into special measures is unlikely therefore to be a useful predictor of fitness to practise activity.

Doctors' overall satisfaction with their training environment and clinical supervision declined during the year a trust went into special measures, but not thereafter.

Satisfaction with their training posts is higher in providers rated as outstanding by the CQC in England than those rated inadequate, but there is such a wide range in satisfaction for providers between these extremes that this indicator cannot be used as a predictive measure when extrapolated up to trust level.

Understanding differences in educational attainment (Chapter five)

This chapter looks at current knowledge and new research on variability in progression through medical education in the UK. It looks at differences depending on the doctor's ethnicity and where they first qualified.

An ethnic gap in average attainment at medical school persists

There is an attainment gap in medical school exams between different ethnic groups, even after accounting for demographic and parental factors, age, learning styles, living at home, first language and prior education.⁵⁵

This year the GMC collected and analysed data across all specialties. The data show lower attainment of BME doctors and non-UK graduates is fairly consistent across all specialties.

- BME UK graduates were more likely (72%) than white EEAs (53%) or IMGs (49%) to get an offer of a post in the first specialty (core) recruitment round, and to pass their exams.
- UK graduates passed their postgraduate exams* over 70% of the time, whereas EEA graduates and IMGs passed less than 50% of the time.

- BME UK graduates were less likely to get an offer of a post in the first recruitment round for those in foundation training applying to Level 1 (L1) training than white UK graduates (72% vs 81%) and less likely to pass their exams, once in training (64% vs 76%).

Identifying doctors training to be GPs who are less likely to do well in their final exams

New independent research shows that trainees doing less well in final GP exams are more likely also to have done less well in the assessments done on entering GP training. It is therefore possible to identify at the outset doctors in GP training who are less likely to do well in their final exams. It is important that appropriate support is made available to these trainees.

At this stage we don't know to what extent these findings apply to other specialties. The GMC is carrying out a comprehensive analysis of exam performance, recruitment and other outcomes that should help to answer this question.

* This includes all attempts, not only the first attempt to pass postgraduate medical exams. Exams data currently only cover one year.

Upholding standards and the remediation of doctors (Chapter six)

This chapter reports on a small study commissioned by the GMC for this report. It surveyed 99 doctors who received warnings or restrictions on their practice between 2006 and 2014, and interviewed 38 doctors and 20 employers in depth. The aim was to try to reach a better understanding of the impact of the warning or restrictions and how this impact has shaped their remediation or development as a doctor.

Successful remediation depends on the attitudes of both doctors and employers

Remediation often depends on both the doctor and their employer being willing and able to make it happen. The doctor has to have the insight to change, and the employer has to be willing to give them adequate support.

Remediation tends to be less successful where doctors perceive the process to have been unfair or where employers do not want to support the doctor or are not able to resource that support. In such cases, doctors report that the warning or restrictions on their practice have had serious consequences for their career.

The extent to which employers are willing to support the doctor varies depending on a wide range of factors. These include their prior experience with the doctor, the resources available, the perceived value of the doctor concerned, the position and attitude of the doctor, the subject and nature of the sanction or warning, whether the employer empathises with the doctor's predicament, and the reputational risk to the organisation.

Improving the potential for remediation

The law is clear – responsibility for remediating lies with the individual doctor. However, in many cases doctors say that, in spite of their best efforts, they are unable to make arrangements that conform with the restrictions that have been imposed by the GMC to ensure patients remain safe.

More successful remediation could be encouraged by a number of interventions. The GMC is currently considering the extent to which it is possible to do the following while keeping patients safe:

- tailor the practicalities of restrictions more to the specific circumstances of both the doctor and employer
- improve dialogue between the doctor and the GMC during the fitness to practise processes (some reforms in this area have already begun)
- publicise more effectively what the warnings and restrictions on practice are and what they are there for.

Creating a more sophisticated range of warnings in terms of length and type tailored to the nature of the concern may also improve remediation. The GMC is considering possibilities in this respect following consultation on the indicative sanctions guidance for warnings.

Resourcing remediation

There is a need for a wider debate about whether and how far society wants to bear the costs of effective remediation of doctors who find themselves unable to practise safely and effectively without restrictions. Some will argue that it has largely to be a matter for the individual to remedy the situation themselves; others point to the opportunities for improved care that reflection and remediation offer, the welfare of the doctors concerned, current resource pressures in the NHS and the financial implications of losing doctors halfway through their career. If the answer is that enabling effective remediation is desirable, a decision will need to be made about who is responsible for resourcing and facilitating it.