GMC – Corporate Strategy and Perceptions Survey 2024

Technical Report

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1. Introduction

This report presents the technical details of the GMC's corporate strategy and perceptions tracking survey 2024. The research was conducted by Shift Insight on behalf of the General Medical Council (GMC). A main report, presenting the findings from the research in detail, has been published separately.

1.1 Overview

Seven audiences were surveyed in this research: patients and the public, medical students, doctors, Responsible Officers (ROs), providers, educators, and stakeholders. All seven audiences were invited to take part in an online survey, while providers and stakeholders were additionally offered the option to take part in a telephone survey. Three surveys (for providers, educators and stakeholders) were launched during the week of 10/06/2024, followed by three more surveys (for medical students, doctors and ROs) during the week of 17/06/2024. The survey for patients and the public went live on 24/06/2024. All surveys closed on 05/08/2024.

1.2 Details of the recruitment approach

Details of recruitment approach and response rates for each audience.

Audience	Method(s)	Number invited to participate	Number of responses	Response rate
Patients and the public	Online survey, sample from third-party provider (Dynata)	N/A	2,038 (1,001 patients; 1,037 public)	N/A
Final year medical students	Online survey, sample from GMC database	9,523	849	9%
Doctors	Online survey, sample from GMC database	41,644	2,599	6%
Responsible Officers	Online survey, sample from GMC database	509	89	17%
Providers	Online and telephone survey, sample from third-party providers (Oscar Research, Wilmington Healthcare)	438	18	4%
Educators	Online survey, sample from GMC database	87	21	24%
Stakeholders	Online survey and telephone survey, sample from GMC database	185	56	30%

Table 1: Summary of audience, method and sample size

2. Sampling and weighting

2.1 Sampling

The sampling strategy for each audience is outlined in detail below.

Patients and the public

This survey audience included patients (those who had received medical advice or treatment from a doctor in the last 12 months) and the public (those who had not received medical advice or treatment from a doctor in the last 12 months). The survey for patients and the public was carried out over six weeks via an online panel, Dynata. The sample was nationally representative of the UK population for the following demographic variables: age, gender, ethnicity, socioeconomic status and NHS region. A representative sample was achieved via data collection and therefore no weighting was applied to the final dataset.

Final year medical students

The sample for all final year UK medical students was sourced from the GMC's medical register. A census approach was taken, meaning that all final year UK medical students on the GMC's register were included in the sampling frame (9,523 records). The GMC contacted the selected sample, providing them with the opportunity to remove themselves from the research prior to the commencement of fieldwork.

Once the appropriate sample was finalised, Shift Insight sent an initial survey invite. During the rest of the fieldwork period, four reminder invites were sent. A chance to enter a £250 prize draw was offered to all who completed the survey.

Shift Insight aimed to achieve a sample that was as representative of the population as possible. For this audience, any small differences between the population and the survey profile were corrected using weighting, described in more detail in the 'Weighting' section.

Doctors

The sample of doctors was sourced from the GMC's medical register. Records were provided for licensed doctors where: the GMC held an email address for them, the individual had a UK registered address, they had not excluded themselves from taking part in research. Further exclusions were applied to the sample, such as removing doctors who were suspended or involved in a Fitness to Practise (FTP) investigation at the time the sample was extracted. In addition, the sampling strategy excluded ROs, stakeholders (including Chairs and Chief Executives), educators, and clinical fellows.

Shift Insight drew an anonymised, stratified sample that was representative of the licensed doctor population by age, gender, ethnicity, region, Primary Medical Qualification (PMQ) area and registration type. This year, the sample selection included oversampling certain groups to ensure representation. This included female doctors; doctors from ethnic minorities; Specialist, Associate Specialist, and Specialty (SAS) doctors; and locally employed (LE) doctors.

The GMC contacted the selected sample, providing them with the opportunity to remove themselves from the research prior to the commencement of fieldwork.

Once the appropriate sample was finalised, Shift Insight sent an initial survey invite. During the rest of the fieldwork period, four reminder invites were sent. Targeted reminder invites were sent to SAS and LE doctors for the final two reminders, to ensure representation across the sample.

Shift Insight aimed to achieve a sample that was as representative of the population as possible. For this audience, any small differences between the population and the survey profile were corrected using weighting, described in more detail in the 'Weighting' section.

Responsible Officers

The RO sample was sourced from the GMC's medical register. ROs were excluded from the doctors' data extract so they could be surveyed separately. A census approach was taken (the GMC held 509 records). The GMC contacted the selected sample, providing them with the opportunity to remove themselves from the research prior to the commencement of fieldwork.

Once the appropriate sample was finalised, Shift Insight sent an initial survey invite to ROs. Over the rest of the fieldwork period, four further reminder invites were sent.

Providers

The sample for providers was sourced from two healthcare database providers, Oscar Research and Wilmington Healthcare. An initial survey invite was sent to this sample and, over the rest of the fieldwork period, four further reminder invites were sent. In previous years, the provider audience had a wider scope and sample, and fieldwork was conducted solely via online survey – however, in 2024, the sample was more targeted, consisting exclusively of CEOs and Chairs, who were offered the option of taking the survey online or via telephone. Due to the more targeted sample, the 2024 survey results will be the new benchmark for this audience, and findings are not tracked to prior years in the main report.

Educators

For the educators sample, the GMC provided the records of undergraduate and postgraduate Deans and Quality Leads at medical education institutions in the UK. A census approach was taken (the GMC held 87 records).

Once the appropriate sample was finalised, Shift Insight sent an initial survey invite to educators. Over the rest of the fieldwork period, four further reminder invites were sent.

Stakeholders

Stakeholders included education bodies, employer organisations, health departments, public bodies, professional bodies and regulators. The sample was sourced using records provided by the GMC, comprising the person within each stakeholder organisation who it was felt had had most prior contact or engagement with the regulator. A census approach was taken (the GMC held 185 records). Referrals were also taken within each organisation where this was requested by the original contact.

Following the initial round of reminder invitations, offering the choice to complete the survey either online or via telephone, four further reminder invites were sent.

2.2 Weighting

Weighting is a statistical technique that adjusts survey results to ensure they accurately reflect the characteristics of a target population. For example, in the collected sample of doctors, 18% were licensed on the GP Register, while the actual population proportion for this group was 21%. To correct for this difference and ensure the sample better represents the overall population, weighting was applied. This process helps ensure the survey findings are more accurate and aligned with the broader population's characteristics. Weighting typically reduces the effective sample size, which is a measure of the survey's precision. The effective sample size indicates the number of respondents the survey results are statistically equivalent to after weighting, reflecting the reliability and accuracy of the weighted data.

As the number of weighted variables increases, the greater the risk that the weighting of one variable will confuse or interact with the weighting of another variable. To reduce the impact of weighting the data, it was applied to as few variables as possible. An effort was also made to minimise the size of the weights. A general rule of thumb

was to not weight a respondent less than 0.5 (a 50% weighting) nor more than 2.0 (a 200% weighting). All research processes were conducted in-house by Shift.

The final cleaned data sample for medical students and doctors were weighted to ensure the results accurately reflected the characteristics of each population. The sample collected for patients and the public was already representative, therefore no weighting adjustments were applied to this audience this year. The samples for ROs, providers, educators, and stakeholders were not weighted, due to their smaller sample sizes.

In addition, to support in validating statistically significant results from 2022 (and 2023, where applicable), population-adjusted weights were applied to the data sets for these audiences: patients and the public, medical student and doctors. This adjustment ensured that all statistically significant differences between survey years accounted for population changes, allowing data from previous years to accurately reflect the current populations of each audience (i.e. reflecting the 2024 populations per audience).

Final year medical students

Survey responses were weighted to reflect the population of final year medical students by ethnicity; other demographic variables were already aligned with the target population. The following table shows the demographic profile achieved in the survey, the weighting targets and then the post-weighting profile of medical students. The post-weighting profile does not match every target exactly as rim weighting on several variables works to achieve a 'best fit' − i.e. not weighting a respondent less than 0.5 (a 50% weighting) or more than 2.0 (a 200% weighting). Rim weighting adjusts respondent weights iteratively across variables to ensure the sample closely aligns with population targets. This method balances the data while preventing any individual response from being overly amplified or minimised.

Profile category		Survey profile (%)	Population figures/ weighting targets (%)	Post-weighting profile (%)
Ethnicity	White	58%	49%	51%
	Asian	24%	31%	30%
	Black	4%	5%	5%
	Mixed	3%	5%	4%
	Other	3%	4%	3%
	Prefer not to say	8%	7%	7%

Table 2: Weighting profile of final year medical students

Doctors

Survey responses were weighted to reflect the population of licensed doctors by registration status, ethnicity and PMQ region. The following table shows the demographic profile achieved in the survey, the weighting targets and then the post-weighting profile of doctors. The post-weighting profile does not match every target exactly as rim weighting on several variables works to achieve a 'best fit' − i.e. not weighting a respondent less than 0.5 (a 50% weighting) or more than 2.0 (a 200% weighting). Rim weighting adjusts respondent weights iteratively across multiple variables to ensure the sample closely aligns with population targets. This method balances the data while preventing any individual response from being overly amplified or minimised.

Profile category		Survey profile (%)	Population figures/ weighting targets (%)	Post-weighting profile (%)
Registration status	Licensed on the Specialist Register	30%	28%	29%
	Licensed on the GP Register	18%	21%	20%
	SAS/LE doctors	21%	28%	25%
	In training	24%	22%	21%
Ethnicity	White	51%	47%	46%
	Asian	23%	32%	29%
	Black	8%	7%	8%
	Mixed	4%	3%	3%
	Other	3%	6%	4%
	Prefer not to say	11%	N/A	9%
PMQ region	UK – within the UK	73%	59%	68%
	EEA – Outside the UK (Europe)	8%	8%	8%
	Outside the UK and EEA (IMG) – Outside the UK (Elsewhere)	19%	33%	23%

Table 3: Weighting profile of doctors

3. Data Processing

3.1 Q SOFTWARE/READER

Q Software/Reader was used for data analysis. By default, Q conducts various tests of statistical significance on tables, such as independent t-tests and Chi-square tests, where applicable. Multiple comparisons correction was applied where appropriate. A p-value of 0.05 was used for significance testing.

3.2 ADVANCED STATISTICAL ANALYSIS

The three advanced statistical analysis techniques utilised in this research were a regression analysis, Key Driver Analysis and segmentation analysis.

Key driver analysis

Key Driver Analysis (KDA) is used to assess how strongly certain factors influence a dependent variable. In this research, KDAs were used to examine how factors such as perceptions of and trust in the GMC influenced the following variables amongst medical students, doctors, and patients and the public:

- Confidence in the GMC or how doctors are regulated (patients and the public)

- Agreement the GMC is an effective regulator
- Agreement the GMC is a relevant regulator
- Agreement the GMC is a compassionate regulator

Each KDA provides an R-squared value (coefficient of determination), which indicates how well the model fits the data. In this context, R-squared measures how accurately the model explains the variation in the actual data. The R-squared value ranges from 0 to 1, with a range of 0.5 to 0.9 being acceptable in social science research, particularly when most explanatory variables are statistically significant. Since doctors had the highest R-squared values for each dependent variable, the KDA was most accurate in predicting the key drivers for doctors for the above variables listed.

The analysis began with inputting all survey variables. Variables were then systematically excluded if they showed no or minimal correlation with the outcome variable for each model. The remaining variables, which demonstrated greater correlations, were retained for further analysis. All the drivers listed in the KDAs below were statistically significant.

Dependent variable: Confidence in the GMC or how doctors are regulated

Patients and the public

Model R^2 / variance explained = 0.489 / 48.9%

Variable	Importance score
Overall, how confident are you personally in doctors in the UK	34.6
I trust the GMC to check that doctors are up to date and safe to practise	9.8
I felt I received good, safe care the last time I received treatment from a doctor	9.5
I trust the GMC to deal with a concern about a doctor's practice or professional behaviour fairly and appropriately, taking into account the context in which the doctor works	8.9
An effective regulator	8.2
I trust the GMC to register doctors who have the right qualifications and skills	8.1
I feel the doctor gave me sufficient information about my health concern or procedure (including any risks associated with them)	7.7
I feel the doctor listened to me properly and took my views into account	6.9
A learning organisation	6.4

*Table 4: **Key Driver Analysis results: Confidence in GMC**. Asked to: Patients and the public (n = 648 [adjusted]).*

Medical students

Model R^2 / variance explained = 0.453 / 45.3%

Variable	Importance score
An effective regulator	17.1
The GMC is focusing on the right issues as a regulator	14.8
A learning organisation	13.7
If a concern about my practice or professional behaviour was made to the GMC, I would trust them to deal with that concern fairly and appropriately, taking into account the context in which I work	13.6
I trust the GMC to protect the quality of doctors' training and education when there are concerns	12.4
The GMC is helping to tackle discrimination experienced by doctors	11.5
I trust the GMC to check that doctors are up to date and safe to practise	8.5
I trust the GMC to register doctors who have the right qualifications and skills	8.2

*Table 5: **Key Driver Analysis results: Confidence in GMC**. Asked to: Medical students (n = 643 [adjusted]).*

Doctors

Model R^2 / variance explained = 0.702 / 70.2%

Variable	Importance score
An effective regulator	13.4
How confident are you in UK-based regulators and healthcare authorities more generally?	10.8
A fair organisation	10.5
If a concern about my practice or professional behaviour was made to the GMC, I would trust them to deal with that concern fairly and appropriately, taking into account the context in which I work	9.8
The GMC is focusing on the right issues as a regulator	9.6
The GMC is improving the way it deals with a concern about a doctor's practice or behaviour	8.7
I trust the GMC to protect the quality of doctors' training and education when there are concerns	8.4
The GMC addresses the right type of concerns about doctors, focusing on the most serious and expecting less serious ones to be resolved locally	8.2
The GMC uses its data, research and insights to support doctors and/or help protect patients	7.4
To what extent do you feel supported by the GMC to deliver good, safe care	7.0
The GMC is helping to tackle discrimination experienced by doctors	6.1

*Table 6: **Key Driver Analysis results: Confidence in GMC**. Asked to: Doctors (n = 1,551 [adjusted]).*

Dependent variable: Agreement the GMC is an effective regulator

Patients and the public

Model R^2 / variance explained = 0.696 / 69.6%

Variable	Importance score
A relevant regulator	17.5
I trust the GMC to deal with a concern about a doctor's practice or professional behaviour fairly and appropriately, taking into account the context in which the doctor works	15.6
I trust the GMC to register doctors who have the right qualifications and skills	14.8
A fair organisation	14.0
A compassionate regulator	13.4
I trust the GMC to check that doctors are up to date and safe to practise	12.4
A listening organisation	12.3

*Table 7: **Key Driver Analysis results: An effective regulator**. Asked to: Patients and the public (n = 1,018 [adjusted]).*

Medical students

Model R^2 / variance explained = 0.739 / 73.9%

Variable	Importance score
A relevant regulator	14.0
A fair organisation	11.8
I trust the GMC to protect the quality of doctors' training and education when there are concerns	11.7
A compassionate regulator	10.8
A listening organisation	10.6
A learning organisation	10.0
How confident are you in the way that the GMC regulates doctors	7.4
I trust the GMC to register doctors who have the right qualifications and skills	7.3
The GMC is helping to tackle discrimination experienced by doctors	7.0
The requirements the GMC will place on me as a doctor will be reasonable and proportionate	5.1
To what extent do you feel supported by the GMC in your studies as a medical student	4.3

*Table 8 **Key Driver Analysis results: An effective regulator**. Asked to: Medical students (n = 623 [adjusted]).*

Doctors

Model R^2 / variance explained = 0.811 / 81.1%

Variable	Importance score
A relevant regulator	12.5
How confident are you in the way that the GMC regulates doctors	10.2
A fair organisation	9.9
A learning organisation	8.4
If a concern about my practice or professional behaviour was made to the GMC, I would trust them to deal with that concern fairly and appropriately, taking into account the context in which I work	8.1
A listening organisation	8.0
The GMC is focusing on the right issues as a regulator	8.0
I trust the GMC to protect the quality of doctors' training and education when there are concerns	7.7
The GMC uses its data, research and insights to support doctors and/or help protect patients	7.6
The GMC is improving the way it deals with a concern about a doctor's practice or behaviour	7.2
GMC perceptions: The GMC is helping to tackle discrimination experienced by doctors	6.2
I would trust the Medical Practitioners Tribunal Service to make a fair, appropriate and independent decision in a tribunal about my practice or professional behaviour	6.1

*Table 9: **Key Driver Analysis results: An effective regulator**. Asked to: Doctors (n = 1,186 [adjusted]).*

Dependent variable: Agreement the GMC is a relevant regulator

Patients and the public

Model R^2 / variance explained = 0.555 / 55.5%

Variable	Importance score
An effective regulator	26.4
A compassionate regulator	15.7
A fair organisation	15.0
I trust the GMC to register doctors who have the right qualifications and skills	14.4
I trust the GMC to check that doctors are up to date and safe to practise	12.5
A learning organisation	10.3
Overall, how confident are you personally in doctors in the UK	5.7

*Table 10: **Key Driver Analysis results: A relevant regulator**. Asked to: Patients and the public (n = 1,023 [adjusted]).*

Medical students

Model R^2 / variance explained = 0.551 / 55.1%

Variable	Importance score
An effective regulator	29.5
A learning organisation	18.8
A fair organisation	18.7
The GMC is focusing on the right issues as a regulator	17.7
I trust the GMC to protect the quality of doctors' training and education when there are concerns	15.4

*Table 11: **Key Driver Analysis results: A relevant regulator**. Asked to: Medical students (n = 723 [adjusted]).*

Doctors

Model R^2 / variance explained = 0.689 / 68.9%

Variable	Importance score
An effective regulator	23.2
A learning organisation	14.4
The GMC is focusing on the right issues as a regulator	13.5
A fair organisation	13.8
The GMC uses its data, research and insights to support doctors and/or help protect patients	12.2
How confident are you in the way that the GMC regulates doctors	11.7
The GMC addresses the right type of concerns about doctors, focusing on the most serious and expecting less serious ones to be resolved locally	11.2

*Table 12: **Key Driver Analysis results: A relevant regulator**. Asked to: Doctors (n = 1,789 [adjusted]).*

Dependent variable: Agreement the GMC is a compassionate regulator

Patients and the public

Model R^2 / variance explained = 0.574 / 57.4%

Variable	Importance score
A fair organisation	16.9
An effective regulator	16.1
A listening organisation	14.8
A relevant regulator	13.5
A learning organisation	12.2

I trust the GMC to deal with a concern about a doctor's practice or professional behaviour fairly and appropriately, taking into account the context in which the doctor works	11.1
I trust the GMC to check that doctors are up to date and safe to practise	8.9
Overall, how confident are you personally in doctors in the UK	6.4

*Table 13: **Key driver analysis results: A compassionate regulator**. Asked to: Patients and the public (n = 1,010 [adjusted]).*

Medical students

Model R^2 / variance explained = 0.780 / 78.0%

Variable	Importance score
If a concern about my practice or professional behaviour was made to the GMC, I would trust them to deal with that concern fairly and appropriately, taking into account the context in which I work	16.6
A listening organisation	14.5
A fair organisation	13.8
A learning organisation	10.0
The GMC is focusing on the right issues as a regulator	9.9
An effective regulator	9.4
The GMC is helping to tackle workplace issues experienced by doctors	9.1
The GMC is helping to tackle discrimination experienced by doctors	8.9
I trust the GMC to protect the quality of doctors' training and education when there are concerns	7.7

*Table 14: **Key Driver Analysis results: A compassionate regulator**. Asked to: Medical students (n = 634 [adjusted]).*

Doctors

Model R^2 / variance explained = 0.792 / 79.2%

Variable	Importance score
If a concern about my practice or professional behaviour was made to the GMC, I would trust them to deal with that concern fairly and appropriately, taking into account the context in which I work	15.2
A fair organisation	14.1
A listening organisation	12.4
The GMC is helping to tackle workplace issues experienced by doctors	10.8
A learning organisation	10.6
The GMC addresses the right type of concerns about doctors, focusing on the most serious and expecting less serious ones to be resolved locally	10.6
The GMC is focusing on the right issues as a regulator	10.0
To what extent do you feel supported by the GMC to deliver good, safe care	8.8
I would trust the Medical Practitioners Tribunal Service to make a fair, appropriate and independent decision in a tribunal about my practice or professional behaviour	7.5

*Table 15: **Key Driver Analysis results: A compassionate regulator**. Asked to: Doctors (n = 1,338 [adjusted]).*

Regression analysis

Regression analysis is a statistical method used to explore the relationship between a dependent variable and one or more independent variables. It allows us to understand whether changes in the dependent variable are linked to changes in the independent variables. In this case, a regression model was applied to assess the strength and direction of the relationship between different sources where respondents heard information about the GMC (independent variables) and their confidence in the GMC (dependent variable).

Each independent variable in the regression has an associated coefficient estimate, representing the magnitude and direction of its relationship with the dependent variable. A larger estimate indicates a stronger relationship, with the estimate measured in terms of the dependent variable (in this case, confidence in the GMC). Like KDAs, regression models also provide R-squared values to indicate how well the model fits the data.

Medical students

Model R^2 / variance explained = 0.430 / 43.0%
Base n = 643

At a 5% significance level, the coefficient estimate for medical students hearing about the GMC from a professional body was significant, with a value of 0.45. This suggests that when this audience reported hearing about the GMC from a professional body, it was associated, on average, with a 0.45 increase in confidence in the GMC. This model similarly controls for perceptions and trust in the GMC. No other sources of information produced significant coefficient estimates.

Doctors

Model R^2 / variance explained = 0.649 / 64.9%
Base n = 1,784

At a 5% significance level, the coefficient estimate for doctors hearing about the GMC from peers and colleagues was significant, with a value of -0.32. This means that when this audience reported receiving information about the GMC from peers and colleagues, it was associated, on average, with a 0.32 decrease in confidence in the GMC. The model also controls for perceptions and trust in the GMC. No other sources of information produced significant coefficient estimates.

Segmentation analysis

Segmentation analysis was used to deepen understanding of the survey data, investigating latent patterns not immediately apparent across the samples for medical students and doctors, that may not be found otherwise. This analysis sought to investigate if medical students and doctors could be grouped by their attitudes and perceptions of the GMC. Specifically, did categories of medical students and doctors emerge, via clustering them based on their confidence and trust in the GMC, their perceptions of the GMC as an effective, relevant and compassionate regulator, and their perceptions of the GMC as a listening, learning and fair organisation? It also aimed to uncover which groups may be more ambiguous or uncertain in their views about the GMC.

K-means cluster analysis was used to investigate this question. K-means cluster analysis is a non-hierarchical clustering method that works by iteratively assigning each data point to a cluster based on its similarity to the cluster's centre, or *centroid*. This is done iteratively, until the optimal centroids and clusters are identified. This approach ensures that k-means finds the most balanced grouping of observations, where each cluster represents a distinct pattern of responses based on the specified variables. It is well suited for analysis of data that is numerical and can be meaningfully averaged, such as continuous variables. In this case, the data was measured on Likert scales, which is easily averaged.

K-means gives the following overall outputs to describe the cluster model: variance explained; and the Calinski-Harabasz value. It also gives, for each variable included in the model: the means for each segment; the R-squared value; and the p-value. The definitions are:

- **Variance explained**: The percentage of total variation in the data accounted for by the clustering solution, reflecting how well the clusters capture the structure of the dataset.
- **Calinski-Harabasz**: A metric that evaluates the quality of the clustering. Higher values indicate more distinct and well-separated clusters.
- **The means for each segment**: The average value of each variable within a cluster.
- **The R-squared value**: Indicates the proportion of variance in each variable that is explained by the cluster membership, with higher values suggesting that the variable strongly differentiates between clusters.
- **The p-value**: The significance level for each variable in distinguishing between clusters. Lower values (<0.05) indicate that the variable significantly contributes to defining the differences among clusters.

Various models, ranging from three to six segments, were created. The models were compared statistically and considered by the GMC, to ensure the most optimal models were selected. A four-segment model was chosen for both medical students and doctors. Two segments from each model were identified as having more ambiguous or uncertain views about the GMC. Other segments in each model were identified as either having mostly positive or mostly negative views towards the GMC.

Medical students

Model R^2 / variance explained = 0.57 / 57%

Calinski-Harabasz: 370

Variable	Segment 1	Segment 2	Segment 3	Segment 4	R-squared	p-value
How familiar are you with the General Medical Council (GMC)	1.97	2.24	2.47	2.67	0.14	0
How confident are you in the way that the GMC regulates doctors	3.58	3.09	2.15	2.62	0.34	0
I trust the GMC to register doctors who have the right qualifications and skills	3.24	1.80	1.38	1.80	0.36	0
I trust the GMC to check that doctors are up to date and safe to practise	3.34	2.02	1.35	1.94	0.39	0
I trust the GMC to protect the quality of doctors' training and education when there are concerns	4.62	3.91	1.71	2.75	0.56	0
If a concern about my practice or professional behaviour was made to the GMC, I would trust them to deal with that concern fairly and appropriately, taking into account the context in which I work	4.62	4.09	1.79	2.97	0.60	0
An effective regulator	4.80	3.40	1.78	2.73	0.60	0
A relevant regulator	4.64	2.25	1.54	2.37	0.60	0
A compassionate regulator	5.06	4.55	2.36	3.76	0.61	0
A listening organisation	4.80	4.65	2.14	3.22	0.67	0
A learning organisation	4.83	4.40	1.96	2.72	0.70	0
A fair organisation	4.85	4.26	1.96	2.96	0.68	0
Sample n	171	159	236	283	-	-
% of sample	20%	19%	28%	33%	-	-

Table 16: ***Segmentation results: four segment model****. Asked to: Medical students (n = 849 [adjusted]).*

Doctors

Model R^2 / variance explained = 0.58 / 58%

Calinski-Harabasz: 1,172

Variable	Segment 1	Segment 2	Segment 3	Segment 4	R-squared	p-value
How familiar are you with the General Medical Council (GMC)	1.88	2.08	1.81	2.01	0.03	0
How confident are you in the way that the GMC regulates doctors	1.71	2.36	3.72	3.12	0.53	0
How confident are you in UK-based regulators and healthcare authorities more generally	1.94	2.60	3.33	3.17	0.30	0
I trust the GMC to register doctors who have the right qualifications and skills	1.23	1.79	3.58	2.02	0.47	0
I trust the GMC to check that doctors are up to date and safe to practise	1.24	1.95	3.92	2.38	0.53	0
I trust the GMC to protect the quality of doctors' training and education when there are concerns	1.40	2.51	4.63	3.63	0.60	0
If a concern about my practice or professional behaviour was made to the GMC, I would trust them to deal with that concern fairly and appropriately, taking into account the context in which I work	1.52	2.84	4.77	4.13	0.67	0
The GMC addresses the right type of concerns about doctors, focusing on the most serious and expecting less serious ones to be resolved locally	1.56	2.80	4.68	3.99	0.58	0
The GMC is improving the way it deals with a concern about a doctor's practice or behaviour	1.88	3.47	4.86	4.34	0.45	0
An effective regulator	1.52	2.50	4.73	3.61	0.68	0
A relevant regulator	1.49	2.33	4.55	3.30	0.58	0
A compassionate regulator	2.04	3.59	4.88	4.61	0.65	0
A listening organisation	1.76	3.11	4.79	4.24	0.64	0
A learning organisation	1.74	2.96	4.76	4.08	0.62	0
A fair organisation	1.75	2.88	4.82	4.21	0.70	0
Sample n	436	712	633	818	-	-
% of sample	17%	27%	24%	31%	-	-

*Table 17: **Segmentation results: four segment model**. Asked to: Doctors (n = 2,599 [adjusted]).*