General Medical Council

The state of medical education and practice in the UK **2016**

Executive summary

Working with doctors Working for patients

Our sixth annual report on the state of medical education and practice in the UK sets out an overview of issues that feature prominently in healthcare, and examines the GMC's data relating to the changing medical register and explores the patterns of complaints about different groups of doctors.

A challenging time

This year's report comes after a prolonged period of upheaval in the health sector, with growing service and financial pressures in the National Health Service (NHS) and a long dispute over new contracts for junior doctors in England.

Growing numbers of people living with multiple, complex, long-term needs, combined with severe financial and staffing pressures in many areas of the healthcare sector, have left many health services unable to cope with rising demand.

A profession not at ease

Many doctors are feeling the pressure, and need to be supported at all levels. Work environments under pressure can have an impact on professional standards and the well-being of doctors. The level of dissatisfaction among doctors seems to be higher than ever before.

Pressure on doctors in training

The 2015 survey revealed that 83% of doctors in training throughout the UK rated the quality of experience in their post as 'excellent' or 'very good'. Yet 98% of those doctors who responded to a ballot called by the British Medical Association (BMA) voted to take industrial action. We are working to do more to listen to doctors in training and identify their concerns. There is a risk that doctors in training might leave the profession if the pressure is too great.

What next?

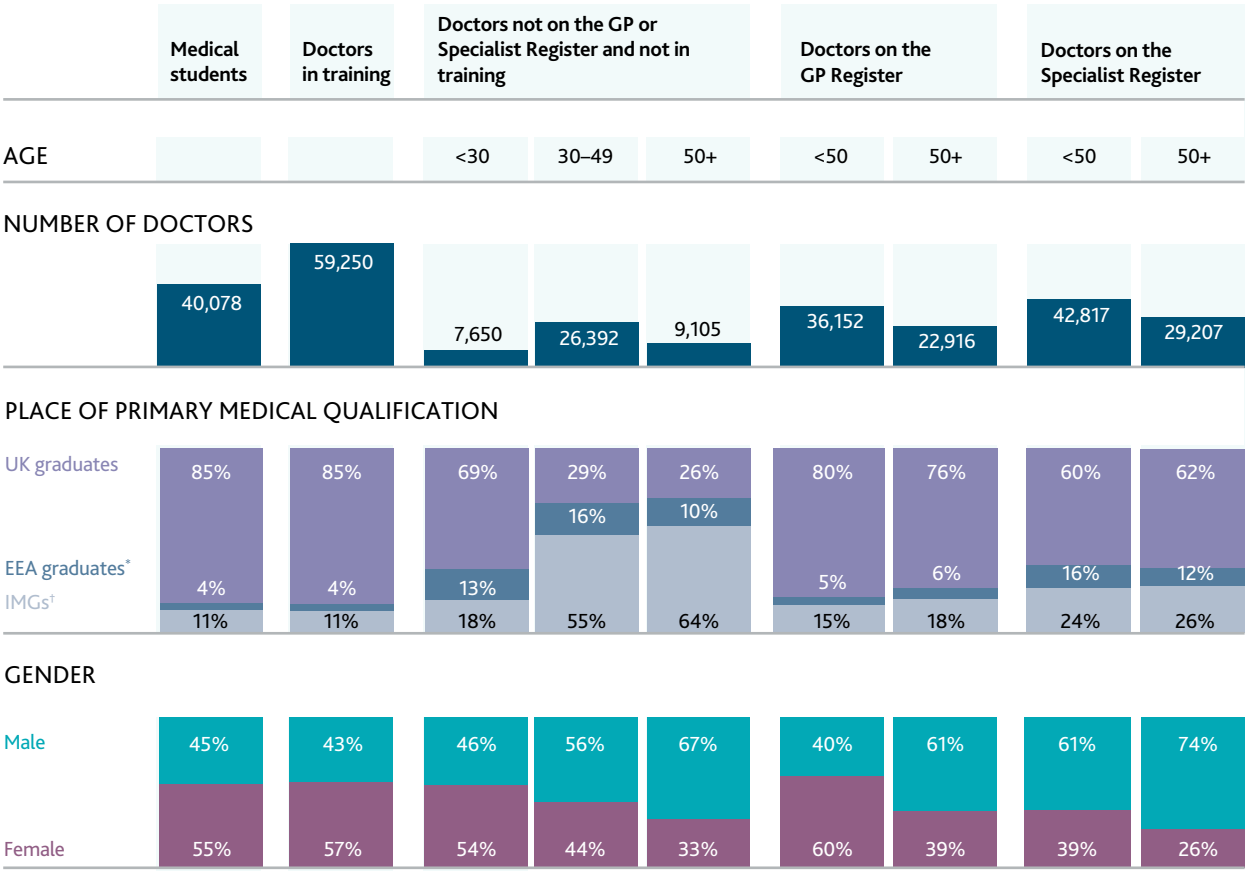
We are the independent regulator of the medical profession across all four countries of the UK and are committed to doing what we can to ensure good professional standards in this difficult environment, and have set the areas we believe we can deliver on. These include:

- making sure education and training matches the needs of doctors and healthcare systems
- engaging with what professionalism means for doctors in the 21st century
- developing a risk-based model of regulation
- engaging with workforce planning
- building on progress with revalidation and making sure regulatory bureaucracy is minimised.

Our data on doctors working in the UK

In this section we show an overview of doctors on the UK medical register, looking at age, gender, place of primary medical qualification and ethnicity. We look at patterns within specialties and changes to the workforce, as well as the revalidation outcomes of different groups of doctors.

Figure 1: Demographic characteristics of licensed doctors on the register and medical students in 2015



GP = general practitioner.

* 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.

† International medical graduates (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.

Number of licensed doctors remains steady

Although the register continued to grow, with an 11% increase in the period 2011 to 2015, the trebling of the number of unlicensed doctors, largely following revalidation means the number of doctors licensed to practice in the UK has remained steady, increasing by only 1% over the period.

An already ethnically diverse profession becoming more so

The ethnic diversity of the profession appears to be increasing. Over the period 2011–15, there was a 22% increase in the number of specialists who described themselves as black and minority ethnic (BME)* against an 8% increase in specialists generally, and an 18% increase in the number of GPs defining themselves as BME, against a 2% increase in GPs generally.

Among GPs and specialists who were UK graduates, a higher proportion described themselves as BME (18% and 16% respectively) than in the UK population overall (13%).

Fewer doctors coming from abroad to work in the UK

The fact that certain specialties rely on non-UK qualified doctors has implications for workforce planners, as the UK is reducing its reliance on doctors who qualified outside the UK over time.

Of the doctors licensed to practise and work in the UK, fewer were from abroad – 10% fewer IMGs and 2% fewer EEA graduates in 2015 compared with 2011. The number of UK graduates had increased by 6%.

The trend for increasing numbers of EEA graduates to come to the UK from southern European countries, such as Italy, Spain, Greece and Portugal, has reversed, with an 11% decrease in 2014–15 after several years of increase.

The growth in female doctors is slowing

Previously we had predicted that the proportion of female doctors would pass the 50% mark by 2017 in the UK, but this may now take longer.

Our analysis this year found that the proportion of registered female doctors grew from 43% in 2011 to 45% in 2015. But the growth in younger female doctors slowed compared with the growth in younger male doctors – the proportion of male doctors under 30 years old increased by 28%, from 2011 to 2015, while that of female doctors increased by only 6%.

Some countries in the UK had already reached gender parity: female licensed doctors made up 51% and 50% in Scotland and Northern Ireland respectively. England had 46% while Wales had 44%.

Update on revalidation

In 2015, almost 70,000 doctors had a recommendation approved by the GMC. Of these doctors 83% were revalidated, while the remainder were deferred. A tiny proportion – 209 doctors – failed to engage. Doctors connected to a locum agency for revalidation were more likely to be deferred than those connected to most other organisations.

* BME includes Asian, black, mixed ethnic groups and other ethnic groups.

Medical students and doctors in training in the UK

In this section we explore the changes in the numbers of medical students and doctors in training, looking at who the doctors were (age, gender, ethnicity, place of qualification) as well as the make-up of specialties where doctors were training and trends in part-time working in training posts.

Data in this section are shown from 2012 onward, when the national training survey was updated.

In 2015, there were 40,078 medical students at UK universities in 2015, a reduction of 3% since 2012.

The demographic make-up of doctors in training is changing

Doctors in training were increasingly likely to have gained their medical degree (primary medical qualification) in the UK, with UK graduates making up 85% of all doctors in training – up from 80% in 2012. Of those doctors in foundation training, 96% were UK graduates.

In particular, in 2015 compared with 2012, there were fewer doctors with an Asian ethnicity in training, mirroring the broader trend that of all licensed doctors non-UK graduates were now less likely to work in the UK – including south Asian doctors, who had historically made up a large part of the workforce.

The specialties in which doctors are training are gradually changing

Psychiatry – as well as obstetrics and gynaecology – saw a drop of 10% in the number of doctors in training between 2012 and 2015. Over a third (41%) of psychiatrists in training were non-UK graduates – the highest proportion of any training programme.

Complaints about doctors

In this section we analyse complaints received by the GMC in 2015 and how these complaints were resolved. We also examine trends over the period 2011–15 and changes in the source of these complaints.

A slowing of a rapid increase in complaints

In 2015, there were 8,269 complaints about doctors' fitness to practise – a 7% reduction since 2014.

Complaints about doctors rose sharply in the two years to 2013, after which they gradually reduced, falling in both 2014 and 2015.

Around one in seven complaints from the public result in investigation

The majority of complaints (68%) came from the public in 2015. This group also accounted for the largest number of complaints in previous years, peaking in 2013 and declining in the following two years. In 2015, 9% of complaints came from other doctors, 6% from employers and 6% from self-referrals.

The percentage of complaints leading to a full GMC investigation varied substantially, depending on the source of the complaint. Just 15% of complaints made by the public in 2015 met the threshold for a full investigation by the GMC, compared with 80% of complaints made by employers, 51% made by the police and 31% made by other doctors.

Outcomes of investigations have remained fairly constant

Of the 2,808 investigations concluded in 2015:

- 5% led to warnings
- 6% led to conditions or undertakings
- 7% led to suspension or erasure.

More than two-thirds were closed with no further action and 14% were closed with advice given to the doctor.

Groups of doctors at higher risk of complaints and investigations

In this section we examine the relative risk of a doctor being complained about, investigated and receiving a sanction or a warning. We also consider variations in risk by register type, source of complaint, age, gender and allegation type.

Risk of complaint and investigation by register

Only 3% of licensed doctors were subject to a fitness to practise complaint in 2015. This rose to 5% for those on the GP register and was lower for those on neither register.

Complaints and investigations are not homogeneous

Some groups of doctors were more likely to have complaints from particular sources and were more likely to be investigated in relation to certain issues than others as shown in figure 3.

Cases about health, criminality, honesty and fairness are more likely to end in a sanction or a warning – and are more likely to come from sources other than the public

Nearly half (45%) of cases stemming from concerns raised by employers involved health, criminality, honesty or fairness, while these types of cases accounted for only one in six (16%) of cases arising from complaints from the public.

These types of cases had a much higher probability of resulting in a sanction or a warning than those involving only issues of clinical competence, which accounted for nearly a third (30%) of investigations arising from public complaints, but less than one in ten (9%) of cases stemming from concerns raised by employers. More than half (55%) of all cases involving a doctor's health resulted in a sanction or a warning compared with 4% of clinical competence cases.

Figure 2: The percentage of doctors complained about and having their complaints investigated, by type of doctor, 2015

	% complained about	Number complained about	% of complaints investigated
			10 20 30 40 50
Doctors on the GP Register	5%	2,755	27%
Doctors on the GP and Specialist Registers	4%	51	24%
Doctors on the Specialist Register	3%	2,319	30%
Doctors not on the GP or Specialist Register and not in training	2%	819	48%
Doctors not on the GP or Specialist Register and in training	1%	405	47%
Total	**3%**	**6,349**	**32%**

Risks of complaint, investigation and warning or sanction for different groups of doctors

Less than one in a hundred doctors actually received a sanction or a warning between 2011 and 2015.

The risk of receiving a sanction or a warning was higher for older and male doctors. Doctors aged 50 years and over were consistently complained about more than younger doctors – and this was true of women and men alike for doctors on the GP, Specialist and neither register. A higher percentage of investigations about younger doctors led to sanctions or warnings.

Compared with white doctors who graduated in the same area of practice, doctors who graduated outside the UK and BME doctors were more likely to receive a sanction or a warning from the GMC.

Figure 3: Proportion of male and female doctors by age who were complained about, had the complaint investigated and received a sanction or a warning during 2011–15

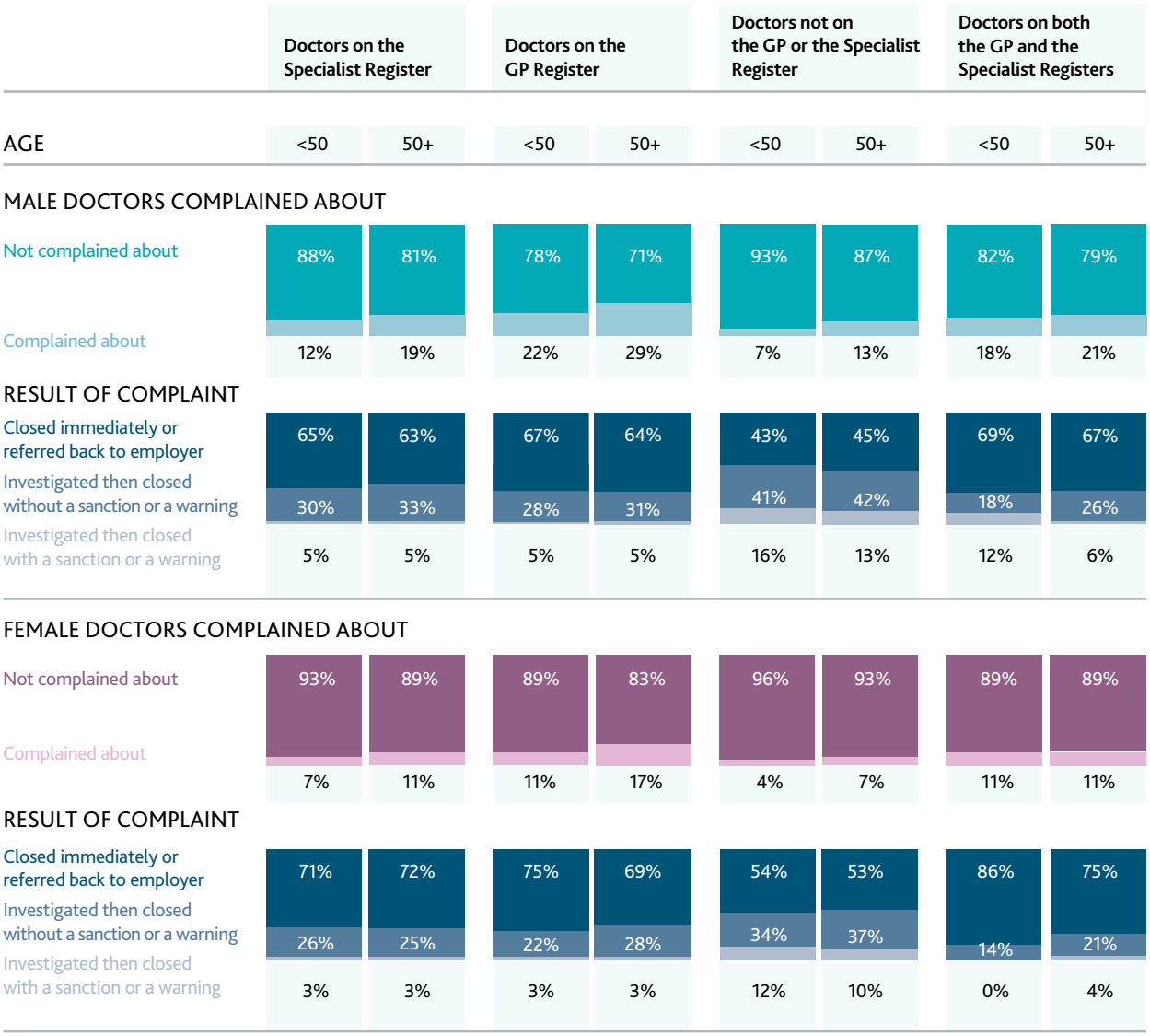
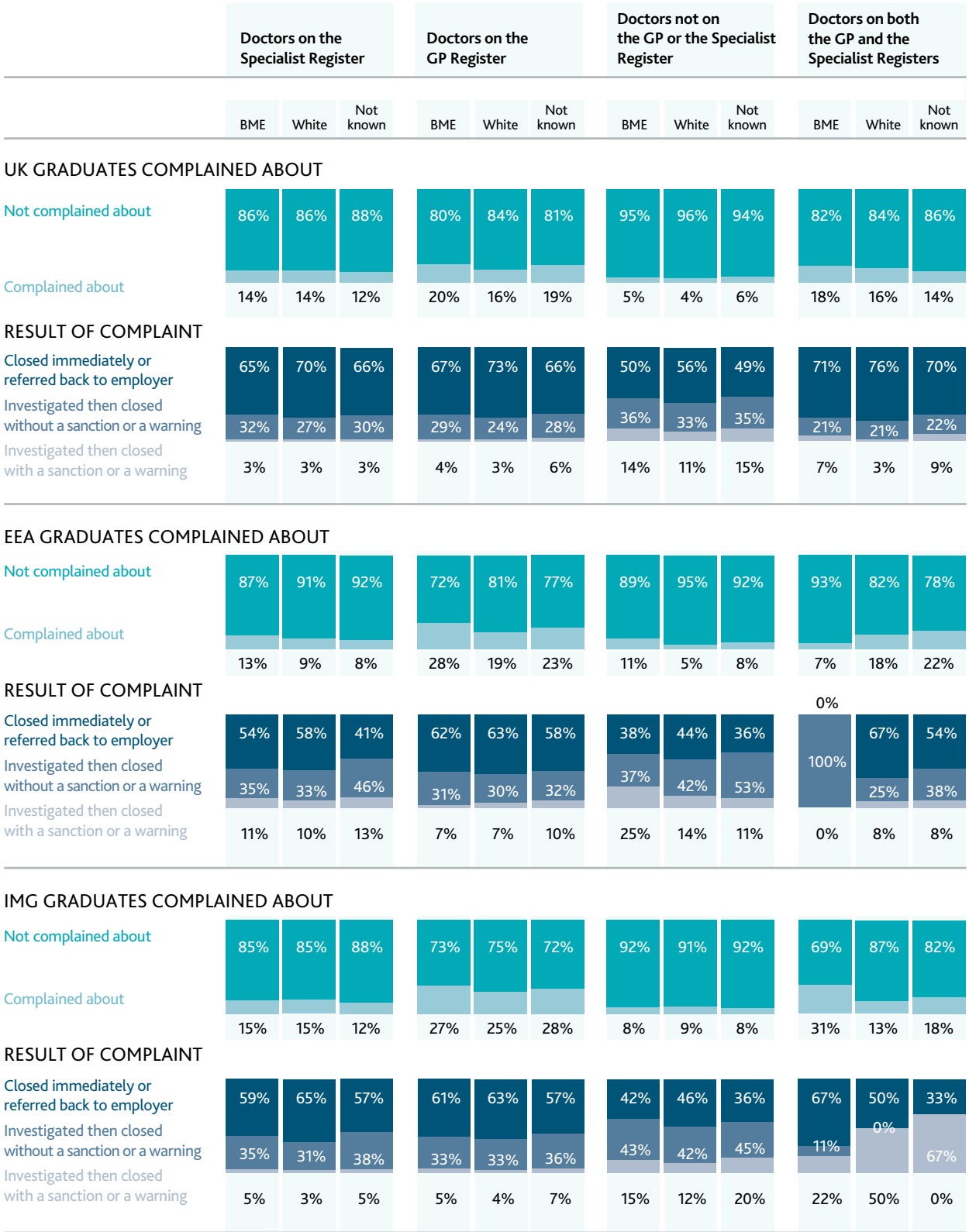


Figure 4: Proportion of doctors who were complained about, had a complaint investigated and received a sanction or warning during 2011–15, by place of primary medical qualification and ethnic group



Regional differences in the types of doctor

In this section we look at how the workforce of GPs and specialists, and doctors who were neither, varied between different parts of the UK and regions in England.

Doctors broadly reflect their local ethnic population

The profession as a whole is more ethnically diverse than the UK, but broadly countries of the UK with higher ethnic diversity have higher diversity in their doctors.

Northern Ireland and Scotland had a very low proportion of doctors who were BME or non-UK compared with the UK average, while England had the highest proportions of both. The English regions with the highest proportions of non-UK doctors were the West Midlands and the East of England (40% each).

Wales has very slightly older GPs

The age profile of doctors varied relatively little between the four countries of the UK. Wales had the oldest profile of GPs, though the difference was small: 43% of GPs in Wales were aged 50 years and over compared with a UK average of 39%.

Wales had fewer GPs than Northern Ireland, despite similar population density. This difference may indicate capacity issues or lower use of GPs in Wales. The Welsh government is planning a campaign to increase GP numbers. The Welsh government are planning a campaign to increase GP numbers.

The future of healthcare regulation in the UK

Why change?

The GMC's role in protecting the public must be shaped by the expectations of the society on whose behalf we regulate, while at the same time retaining the consent of the doctors. Regulation is changing and the GMC must be involved in these changes.

Increased expectations of regulators

The GMC must support doctors in the work that they do. The best way to do that is not by taking action when things have gone wrong and patients (and often doctors themselves) have already been harmed. It is by directing our resources to support good practice and, where we can, mitigate the risks of harm occurring.

Promoting professionalism

We seek to instill the standards of behaviour for good medical practice. Our proposals for a new medical licensing assessment support this approach, while allowing medical schools the flexibility to go beyond our requirements if they wish to do so. The proper aim of regulation should go beyond the assurance that practising doctors are not 'bad', and promote the sort of professionalism that most of us would want to take for granted.

Preventing harm

The work of our Regional Liaison Service and offices in Scotland, Wales and Northern Ireland is a good example of engaging with the profession to promote good practice across the profession. The same is true of our work in medical education and training, and revalidation.

Risk-based regulation

Following the work of the Better Regulation Executive, regulators have been increasingly focused on making sure their regulatory activities are guided by an understanding of risk in the regulated area. Risk-based regulation offers a more proportionate regulatory response to problems, and it enables regulators to put in place interventions that can help prevent risks materialising as actual harms.

Improved data and intelligence sharing will help regulators target their activities more effectively. It should also mean that the demands on individual doctors and the wider healthcare system to provide the same or similar data for multiple agencies can be reduced because data can be collected once and used for multiple purposes.

The future shape of regulation

The UK government's latest initiative to examine the future of professional regulation is therefore welcome. It promises to consider the purpose of regulation, alongside issues of autonomy, efficiency and cost-effectiveness.

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