

General  
Medical  
Council

# The state of medical education and practice in the UK

2012

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Regulating doctors  
Ensuring good medical practice





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# Contents

<b>Foreword</b>	<b>03</b>
<b>Executive summary</b>	<b>04</b>
<b>Introduction</b>	<b>06</b>
The changing nature of medical practice and the systems in which doctors work	06
Variation in patient outcomes	10
Better information can drive change	11
The aim of this year's report	13
<b>Chapter 1: Changes in the medical profession since last year</b>	<b>14</b>
Summary of chapter	15
Section 1: The profession in 2011	16
1.1 Doctors on the register	16
1.2 Number of registered doctors	20
1.3 Gender	20
1.4 Age	23
1.5 Place of primary medical qualification	23
1.6 Medical education and training	28
Section 2: Complaints about doctors	30
2.1 Complaints in 2011	33
2.2 Volume of complaints	34
2.3 Who complained?	37
2.4 Who did complaints tend to be about?	39
2.5 What did people complain about?	40
Conclusion	46
Chapter 1: A note on data	48
<b>Chapter 2: Medical practice at different stages of doctors' careers</b>	<b>50</b>
Summary of chapter	51
Section 1: Patterns in allegations at different stages of doctors' careers	52
Section 2: Stages of the medical career	55
2.1 Medical students and doctors in training	55
2.2 Where a doctor qualified	59
2.3 Doctors on the GP or Specialist Register	63
Section 3: Doctors in service posts	68
3.1 Locum doctors	68
3.2 Specialty doctors	69

Section 4: Health concerns	71
4.1 Health concerns and fitness to practise	71
4.2 Health concerns at different stages of career	73
Conclusion	76
Chapter 2: A note on data	77
<b>Chapter 3: Doctors in the workplace</b>	<b>78</b>
Summary of chapter	79
Section 1: Where doctors work	80
1.1 There is little difference in complaints across the four UK countries and health systems	80
1.2 Types of allegations investigated at a regional level	80
Section 2: The organisations in which doctors work and train	83
2.1 Organisational size	83
2.2 Workforce issues and their impact on medical training and practice	84
2.3 The impact of organisational culture	88
Section 3: The patients who doctors treat	95
Conclusion	97
Chapter 3: A note on data	98
<b>Chapter 4: Overcoming barriers to good medical practice</b>	<b>100</b>
Section 1: The state of medical education and practice in the UK	101
Section 2: The size and shape of the medical workforce	102
Section 3: The rising tide of complaints	104
Section 4: Tailoring support for doctors across their career	106
Section 5: Organisational factors affecting performance	108
Conclusion	111
<b>References</b>	<b>112</b>
<b>Glossary</b>	<b>130</b>
<b>Appendix: The medical register across the UK</b>	<b>140</b>
<b>Acknowledgements</b>	<b>142</b>

# Foreword

The GMC holds a large amount of information which in many ways gives us a unique overview of medical education and practice in the UK.

We collect information mainly as a consequence of carrying out our statutory functions: maintaining the medical register; fostering good medical practice; regulating undergraduate and postgraduate medical education; and investigating doctors whose fitness to practise has been called into question. In addition, we collect data given to us voluntarily, such as ethnicity, age and area of practice.

Last year, for the first time, we published much of what the GMC knows about the medical profession and this was very well received, collecting together as it did, in one place, a great deal of very interesting information. We present here the second edition of *The state of medical education and practice in the UK*.

Over the last three decades, doctors have consistently been the most trusted profession in the UK: among 15 Ipsos Mori polls of public trust over that period, doctors have always been at the top.<sup>1</sup> This is clearly reassuring. However, as the regulator charged by Parliament since 1858 with the task of protecting the public by ensuring high standards of medical education and practice, we have a duty to ensure that this enviable situation continues.

We hope that this report and the information which it contains will help in that task, not least by helping to understand the barriers doctors might face in meeting our standards and how the settings in which they work might contribute to their ability to practise as they would wish.



**Professor Sir Peter Rubin**  
Chair, GMC

# Executive summary

*The state of medical education and practice in the UK: 2012* seeks to contribute to a wider understanding of the medical profession.

We have used our data and data from other sources to reflect on the medical profession as it is today and to consider what it might need to become in the future. In so doing, we aim to promote discussion and debate, and ultimately to contribute to better medical care for patients throughout the UK.

## Key findings

### Changes in the medical profession since last year (chapter 1)

- In 2011, the number of doctors on the register continued to grow, and, for the first time, the number of women doctors on the register exceeded 100,000.
- A third of the UK's doctors qualified outside the UK but we are starting to see changes in the profile of countries they come from.

- The number of complaints we received has continued to rise, particularly those from members of the public.
- In 2011, the GMC received proportionally more complaints about men, older doctors and GPs. This is consistent with the pattern of complaints in 2010.
- A small number of doctors fell seriously short of the standards expected of them. We erased 65 doctors in 2011, permanently removing their right to practise medicine in the UK.

### Medical practice at different stages of doctors' careers (chapter 2)

- We investigated proportionally more allegations about clinical care and relationships with patients for doctors who graduated from medical school between ten and 20 years ago. Allegations about relationships with patients tended to involve issues about doctors' communication skills and how they interact with their patients.
- Where in the world doctors qualified did not affect the overall likelihood of them being complained about, but did affect the type of complaint.

- How doctors gained specialist or GP registration did not influence the likelihood of them being complained about. But the specialty they worked in did.
- Only a very small number of complaints were about doctors' health. The types of health issues varied at different stages of doctors' careers.
- more data to help doctors in training make decisions about their future role and place of work, based not just on their ambitions, but on the needs of society and gaps in service provision.

### Doctors in the workplace (chapter 3)

- There was little difference in complaints across the four UK countries and health systems.
- The size of the organisation in which doctors work can impact on patient outcomes and patterns of complaints.
- There is evidence that patient outcomes are worse on evenings and weekends, times when there is less senior doctor cover.
- Organisations where doctors in training reported below average satisfaction with clinical supervision also had a higher proportion of complaints to the GMC.

## Overcoming barriers to good medical practice (chapter 4)

### 1. The size and shape of the medical workforce

As the profession changes, so must its engagement with wider society. There needs to be:

- a shared understanding about what is expected of our doctors and what support is required
- more flexibility within medical careers to meet the changing needs of doctors in training, patients and healthcare providers

### 2. The rising tide of complaints

We need to understand:

- what might lead to a complaint
- what support doctors might need
- which groups of patients complain, what they complain about, and the environments from which complaints arise.

### 3. Tailoring support for doctors across their career

We and others need to:

- ensure that doctors have tailored support to help them overcome the challenges they face at different stages of their career
- understand how the standards we set can be applied in a meaningful way to doctors' day-to-day work and provide more guidance and advice.

### 4. Organisational factors affecting performance

There needs to be a better understanding of the environments in which doctors work and train, and their impact on ensuring high standards of practice. As we continue to analyse fitness to practise trends at a regional and a trust or board level, and share these data with others, we hope to gain a better understanding of how organisational factors can affect medical practice.

# Introduction: The changing nature of medical practice and the systems in which doctors work

In last year's report, we found much to celebrate in the UK's medical profession. At the same time, we found some evidence of variation in standards of both medical education and practice, and highlighted a number of areas where we and others need to take action for improvement.

These themes have continued. The number and proportion of female doctors is growing in the UK and the UK medical workforce is more ethnically diverse than the general population.<sup>2</sup> Also, the number of doctors drawn to the attention of the GMC who are falling seriously short of the standards expected of them remains very small.<sup>3</sup>

The medical profession is also continuing to adapt to new challenges like implementation of the Working Time Regulations (WTR),<sup>4,5,6</sup> brought in as a result of European legislation, technological advances and changing patient expectations.<sup>7,8</sup>

There has also been considerable financial pressure and reform of the National Health Service (NHS).

### Responding to the changing healthcare needs of the population

Healthcare needs are changing. The medical specialties with the largest number of doctors are not necessarily those in which there is greatest patient need, and there are continuing shortages in psychiatry and general practice.<sup>9</sup>

The UK's rapidly ageing population<sup>10</sup> and public health issues, including the rising number of patients with long-term conditions and comorbidities,<sup>11,12</sup> are already changing the nature of medical practice. These external factors will also require changes in medical education and training, not least to equip the next generation of doctors to care for patients with more than one condition. The Commission on

Medical Generalism, set up by the Royal College of General Practitioners and the Health Foundation, noted that there needs to be 'a fundamental reappraisal of how medical students are taught to think about illness and disease... Trainee doctors will need to focus much less on narrow disease silos and to focus much more on the breadth of possible permutations of comorbidity'.<sup>13</sup> The changing demography of UK society also means that, for the vast majority of doctors (with the obvious exception of paediatricians and obstetricians), the largest group of patients for whom they care will be older people. Already 65% of people admitted to hospital are aged 65 years or over, and they account for 70% of all hospital bed days.<sup>14</sup> Caring for older people has never been the sole domain of those specialising in geriatric medicine. But nor has it been sufficiently recognised that treating older patients is a fundamental and dominant aspect of the clinical practice of most doctors. Given the nature of illness in later life, this does suggest that all doctors need to be better equipped to care for patients in a way that extends beyond their particular clinical specialty.

### Showing leadership and challenging poor practice

There has been continuing evidence of failure to provide adequate care for both older people and those with learning disabilities, notably in hospital and residential care settings, with numerous examples of care that falls well below the required standards.<sup>15,16,17,18</sup> Events at Mid Staffordshire NHS Foundation Trust<sup>19</sup> and Winterbourne View Care Home,<sup>20</sup> and the BBC's *Panorama*<sup>21</sup> exposure of the mistreatment of a resident with dementia in Ash Court, a London care home, have demonstrated

that, even in a supposedly sophisticated and well regulated system, the most vulnerable can be at serious risk of abuse and neglect. There is evidence too of a wider malaise found across all care settings, whereby older people are not treated with dignity and respect.<sup>22, 23, 24</sup>

Although a doctor may not be at a patient's or resident's bedside as often or as continuously as a nurse or a care assistant, they should have a good overview of a patient's condition and have overall responsibility for their care and welfare. Regardless of professional background, all those working in healthcare have a responsibility to help to ensure there are systems in place to deliver a high standard of care.

Where they see evidence that care is not adequate, all doctors must act. If they are not willing to contribute to improving the quality of services and to speak up when things are wrong, patients are likely to suffer. These responsibilities are underlined in our guidance both on doctors' leadership and management responsibilities and on raising concerns.<sup>25, 26</sup>

In recent years, there has been discussion on the need for a new type of medical professionalism that reflects changes in the ways doctors relate to evidence, society, patients, teams, regulators, employers and technology.<sup>27, 28</sup>

This debate is by no means concluded and, if the profession is to respond to external changes, including the different expectations from patients, employers and younger doctors, we need to take the debate further. The norm is for doctors to work in teams and within organisations. At the same time, society's expectations and values continue to change. It is important that the role, limits and value of medical practice are agreed between doctors, the organisations in which they work and wider society, based on a shared understanding of what good practice looks like.

Leadership is needed here, and the GMC and medical and health organisations can make a vital contribution to help foster this developing compact.

### Changes to the organisation and delivery of healthcare services

The NHS in England has continued to be subject to considerable organisational change and, although the passing of the Health and Social Care Act 2012 earlier this year has provided a blueprint for the way forward, uncertainties remain, not least around the organisation and delivery of medical education.<sup>29</sup>

For general practitioners (GPs) in particular, who will assume responsibility for commissioning healthcare services from primary care trusts in England from April 2013,<sup>30</sup> the new system is certain to bring opportunities as well as challenges.

The countries of the UK operate different health systems, and financial pressures continue to be felt across these, with a frequently quoted £20 billion efficiency saving required for England alone.<sup>31</sup> The low growth or no growth pattern of NHS spending in England is now expected to last at least until the end of this decade. And a report published by the Nuffield Trust in 2012 suggested that the proposed spending plans for 2010–11 to 2014–15 would, if delivered, represent the tightest four-year period of funding in the NHS in the past 50 years.<sup>32</sup>

In Northern Ireland, spending on health and social care has increased by 13.4% from £3,902.4 million in 2007–08 to £4,423.4 million in 2010–11.

However, that rate of growth is now set to slow down; with a planned 7.5% increase in the current budgeting period to a total spend of £4,757.1 million for 2014–15; in effect a real-terms decrease given rises in inflation over that period.<sup>33, 34</sup>

In Scotland, the Government has committed to increase the NHS resource budget by £249 million giving a total budget of £11.6 billion in 2012–13. This is a 2.3% increase from 2011–12.<sup>35</sup> However, although cash funding for the NHS has continued to increase, higher inflation means that funding is decreasing in real terms. There has been a 1.4% real-terms decrease in funding between 2010–11 and 2011–12, and the Scottish Government's 2011 spending review outlined a 4.2% real-terms decrease in NHS funding in the five years to 2014–15.<sup>36</sup>

In Wales, spending on health has increased above inflation every year since 2006, peaking at a 7% increase in 2007–08, and falling back down to about 3% in 2010–11.<sup>37</sup> And the NHS in Wales is now projected to face a funding gap of between £1.3 and £1.9 billion by 2014–15 unless steps are taken to change the way care is delivered.<sup>38</sup>

The NHS Confederation in England has warned the pressure on the NHS is greater than 12 months ago and is set to increase.<sup>39</sup> There have also been reported impacts on some areas of service delivery and patient access, such as waiting times in accident and emergency departments in England.<sup>40</sup>

A similar pattern can be seen across other health systems. 2012 data from the Organisation for Economic Cooperation and Development (OECD) show that health spending has slowed or decreased in real terms across almost all OECD countries.<sup>41</sup>

The four UK countries are likely to address the need for efficiencies in different ways, and it is possible that financial pressures will accelerate demands for new organisational structures and care models.

There is a wide consensus that some form of reconfiguration of hospital and community services will be essential, not only to achieve efficiency savings, but also to respond to workforce pressures and maintain safe levels of care.<sup>42</sup>

Quality, workforce and financial pressures have been cited in the reconfiguration of stroke services implemented in London,<sup>43</sup> and in subsequent calls to centralise specialist services from the Royal College of Paediatrics and Child Health<sup>44</sup> and from the Royal College of Obstetricians and Gynaecologists.<sup>45</sup>

In Wales, following a review of the configuration of hospital services, proposals have been made to centralise some services to help respond to unsustainable workforce pressures, and to improve outcomes, particularly in those specialties where evidence points to significantly improved results for patients cared for in specialist centres.<sup>46</sup>

Proposals across Wales,<sup>47</sup> England<sup>48,49</sup> and Northern Ireland<sup>50</sup> have also centred on moving care from hospital to community settings, where clinically appropriate. This can bring challenges in ensuring seamless patient pathways across multiple care providers, but also opportunities, including increased use of telehealth solutions to improve support for patients with long-term conditions in the community, and thereby avoid unnecessary hospital admissions.<sup>51, 52, 53</sup>

There have also been calls for more integrated care models to support older people and patients with long-term conditions and comorbidities, who need access to coordinated services from a number of health and social care providers.<sup>54, 55, 56, 57</sup> Integrated care is a phrase that can mean different things in different contexts – there are various models and approaches such as improved coordination (including pooled commissioning budgets) across primary,

community and secondary care, and merging services, so that a single organisation is responsible for delivery at every stage.<sup>58</sup> There have also been calls for the integration of health and social care,<sup>59</sup> an idea that the Scottish Government is currently consulting on.<sup>60</sup>

Whatever the form, new models of care may present challenges for doctors, who could be required to work in new ways, in different healthcare settings, and in teams (sometimes virtual) that span organisational boundaries. These new models may also raise more challenging questions about the structures for medical education and the profession itself, including whether the make-up of today's medical profession is sufficiently aligned to changing patient needs, and whether there needs to be a more even balance between medical generalists and specialists.

## Variation in patient outcomes

There has been growing concern over the apparent link between service organisation and patient outcomes. Several studies have shown poorer outcomes on evenings and weekends when fewer staff, and in particular fewer senior doctors, are on duty.<sup>61, 62, 63, 64, 65, 66</sup>

This is an area in which the profession can and should take a lead, and it underlines the importance of determining the right level of supervision and support for doctors in training (see chapter 3).

The evidence of organisational arrangements that are not fit for purpose may reflect a wider disconnect between doctors and the systems in which they work. Many inquiries have identified a sense of alienation among clinicians and this was a significant factor in the failings highlighted at Mid Staffordshire NHS Foundation Trust.<sup>67</sup>

The extent of this is hard to determine but anecdotally it is not hard to find doctors who feel frustrated by the institutions in which they work. Even among those at a senior level, there is often a sense of impotence in the face of what they see as burgeoning bureaucracy.<sup>68</sup> As Professor Sir Graeme Catto said, 'The [medical] profession is often regarded as being arrogant...actually it is its diffidence and the fact that it does not sell particularly well [what it is doing] that is equally a problem'.<sup>69</sup>

This sense of separation felt by doctors from the institutions in which they work is a cause for concern – apart from anything else they are less likely to raise concerns about patient safety and poor standards of care.<sup>70</sup> As with the closely related area of medical professionalism, addressing these issues will require more open discussion, clear leadership and significant cultural change within organisations.

## Better information can drive change

One of the major consequences of the digital age is the growing importance of data and its capacity to drive change. Access to data not only provides opportunities for professionals to understand the nature of what they are doing and how they are performing, but can also transform the relationship between them and their patients. For policymakers, employers and regulators, well analysed information and better identified trends should also lead to a better understanding of the areas for which they are responsible and better targeted interventions.

One obvious example is patient care data – a key driver to identifying poor standards and unwarranted variation.<sup>71, 72, 73</sup> The use of data not only helps pinpoint where things are going wrong and why, but also where healthcare is working well.

A striking example of this has been the national patient safety programme in Scotland,<sup>\*</sup> which has used the hospital standardised mortality ratio (HSMR) to help both identify the reasons behind hospital mortality and identify opportunities for improved patient care.<sup>74</sup> From December 2007 to February 2012, Scotland experienced a 9% reduction in the hospital death rate.<sup>75</sup>

\* The Scottish Patient Safety Programme, established in 2011, aims to reduce mortality by 15% and adverse events by 30% across Scotland's acute hospitals.

The reporting of outcomes by the Society for Cardiothoracic Surgery since 2001 has also contributed to significant improvements, with a halving of mortality rates within five years and greater standardisation of practice as poor performing areas came up to the national average.<sup>76</sup>

The introduction of revalidation, expected later this year,<sup>\*</sup> provides a great opportunity to build on work such as this, by bringing evidence to the centre of every doctor's evaluation of their practice, and by changing the way individuals, teams and organisations approach professional practice. Revalidation is the process by which licensed doctors will regularly demonstrate to the GMC that they are up to date and fit to practise. As Professor Sir Bruce Keogh (then president of the society) noted, publishing the data brought a 'major philosophy and mindset change' – it encouraged doctors to examine outcomes data and critically reflect on their own performance, and that of their colleagues.<sup>77</sup> Increasingly, both healthcare organisations and professionals will have a duty to make the data they collect publicly available,<sup>78</sup> particularly information about the outcomes of their interventions.

This digital revolution is throwing up many new technical challenges in sharing data, as well as cultural barriers. As we move towards a more transparent system, it is vital that patient confidentiality is always protected.

In England, the Government's information strategy and recently established Health and Social Care Transparency Panel are signs of the greater attention that data collection, analysis and sharing are

receiving. The Panel is considering and advising on the release of large public service datasets – their task is to enable patients and others who use services to access their own data and records, and to support individuals and organisations to obtain fast and easy access to healthcare data.<sup>79</sup>

At the GMC, we are conscious of the unique data we hold and the fact that there is more we can do to analyse and share these data with the profession and the wider healthcare system. This report is an important step in that direction. We do recognise the limits of our data – sometimes a variation or trend may merit no more than a question, or prompt further analysis. But we believe that by setting out what we and others know about medical education and practice, we can reflect on the challenges and issues facing the profession, and the actions we and others need to take in response.

As the regulator with responsibility for medical education, training and practice, we want to bring together data about different stages of doctors' careers, and to understand how different factors affect how doctors train and work. This report starts that process. We will continue to look at how we can improve the data we hold, but also how that can be compared with other data sources to improve our own and others' understanding of the medical profession.



**Niall Dickson**  
*Chief Executive and Registrar, GMC*

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\* Subject to the Secretary of State for Health's approval.

## The aim of this year's report

This report aims to answer two questions.

The first is what has changed about the medical profession since last year's report?

The second question is more complex: what barriers do doctors face in delivering high quality care for patients and meeting the standards set in our core guidance, *Good Medical Practice*, and why are some doctors better able to do this than others? Some barriers may be individual to the doctor, whereas others are linked to the environment in which they work.

We also hope this report will encourage debate, reflection and practical steps to improve patient care. By starting to identify the causes of variation, we should be able to find ways of overcoming barriers to good practice.

The report covers three main areas.

- *Changes in the medical profession since last year* (chapter 1) updates on the key indicators about the profession from last year's report, and reflects on significant changes.
- *Medical practice at different stages of doctors' careers* (chapter 2) looks at how the types of complaints vary, and the importance of tailoring support for doctors.
- *Doctors in the workplace* (chapter 3) assesses the variability across these different environments, and considers how these factors can constrain and support good medical practice.

The final chapter, *Overcoming barriers to good medical practice* (chapter 4), considers the changes that may be required to meet existing and future challenges.

# Chapter 1: Changes in the medical profession since last year

This chapter sets out some key statistics about the medical profession, drawing primarily on registration, education and fitness to practise data from 2011. In some places, we compare with data from 2010 to highlight changes or trends.

## Summary of chapter

This chapter gives key indicators on the make-up of the profession in terms of gender, nationality, and complaints to the GMC and the wider health service. It also examines what might be driving those changes since we published baseline figures from our data last year.

### Key findings

- In 2011, the number of doctors on the register continued to grow, and, for the first time, the number of female doctors passed the 100,000 mark.
- Changing lifestyles and expectations of doctors mean that the need for flexible working and training is becoming increasingly important.
- A third of the UK's doctors qualified outside the UK. We have started to see changes in the countries from which doctors come to the UK, with the profession shaped by external factors.
- The number of complaints has continued to rise. We received 8,781 complaints in 2011, up 23% from 7,153 in 2010. This appears to be part of a wider pattern experienced both internationally and in terms of complaints about other health professions across the UK.
- We saw a particular increase in complaints from patients. The greatest areas of increase since last year were the issues that patients, as opposed to doctors, tend to complain about. These issues included how doctors relate to patients and doctors' openness with patients.
- In 2011, we received proportionally more complaints about men, older doctors and GPs. This is consistent with the pattern of complaints in 2010.
- A small number of doctors fell seriously short of the standards expected of them. We erased 65 doctors in 2011, permanently removing their right to practise medicine in the UK.

## Section 1: The profession in 2011

### 1.1 Doctors on the register

- There were 245,903 doctors on the medical register in the UK on 31 December 2011. (See figure 1.1 on page 18.)
- 12,626<sup>\*</sup>,<sup>†</sup> doctors joined the register during 2011 and 7,051 left. The vast majority of those leaving (6,986) did so for reasons unrelated to their fitness to practise.
- 232,769 doctors held a licence to practise, a rise of 6,087 from 2010, leaving 13,134 who were registered but not licensed to practise.
- Doctors registered across the four UK countries were as follows:<sup>‡</sup>,<sup>§</sup> (See appendix on page 141.)
  - England: 183,019 (177,659 with a licence); 57% men, 43% women
  - Northern Ireland: 6,674 (6,454 with a licence); 53% men, 47% women
  - Scotland: 20,151 (19,373 with a licence); 52% men, 48% women
- Wales: 10,746 (10,400 with a licence); 59% men, 41% women.
- The number of female doctors increased from 99,889 in 2010 to 104,534 in 2011, exceeding 100,000 for the first time. The number of male doctors increased from 139,381 to 141,369.
- The average age of doctors on the register increased slightly from 39.8 years in 2010 to 39.9 years in 2011.<sup>¶</sup> The average age of doctors with a licence to practise increased from 39.5 years to 39.6 years. The peak age of doctors on the register is 35.
- Doctors with a non-UK primary medical qualification<sup>\*\*</sup> made up 37% of registered doctors, consistent with 2010.
  - Of these, 24,031 (10% of all registered doctors) gained their primary medical qualification from countries in the European Economic Area (EEA) and 66,608 (27% of all registered doctors) gained their primary medical qualification from countries in the rest of the world, international medical graduates (IMGs).

\* Does not include restorations to the register.

<sup>†</sup> Includes doctors who have previously held limited registration for a period of time.

<sup>‡</sup> This relates to the doctor's registered address, which may differ from where the doctor is currently practising medicine.

<sup>§</sup> These numbers were based on each doctor's registered address as opposed to their place of practice. Other categories include non-UK, Channel Islands, Isle of Man and unspecified.

<sup>¶</sup> There is an ongoing effort to improve the information we hold on doctors' age. Since publishing last year's report, *The state of medical education and practice in the UK: 2011*, the quality of age data has improved from 84.5% of the register to 96.5% of the register. Consequently, average ages quoted for 2010 in this year's report differ slightly from last year. The current average age of registered doctors (mean, median, mode) is 42.3, 39.8 and 34 years for 2010, and 41.8, 39.9, 35 years for 2011.

\*\* Gained on completion of undergraduate medical education (ie on graduation from medical school).

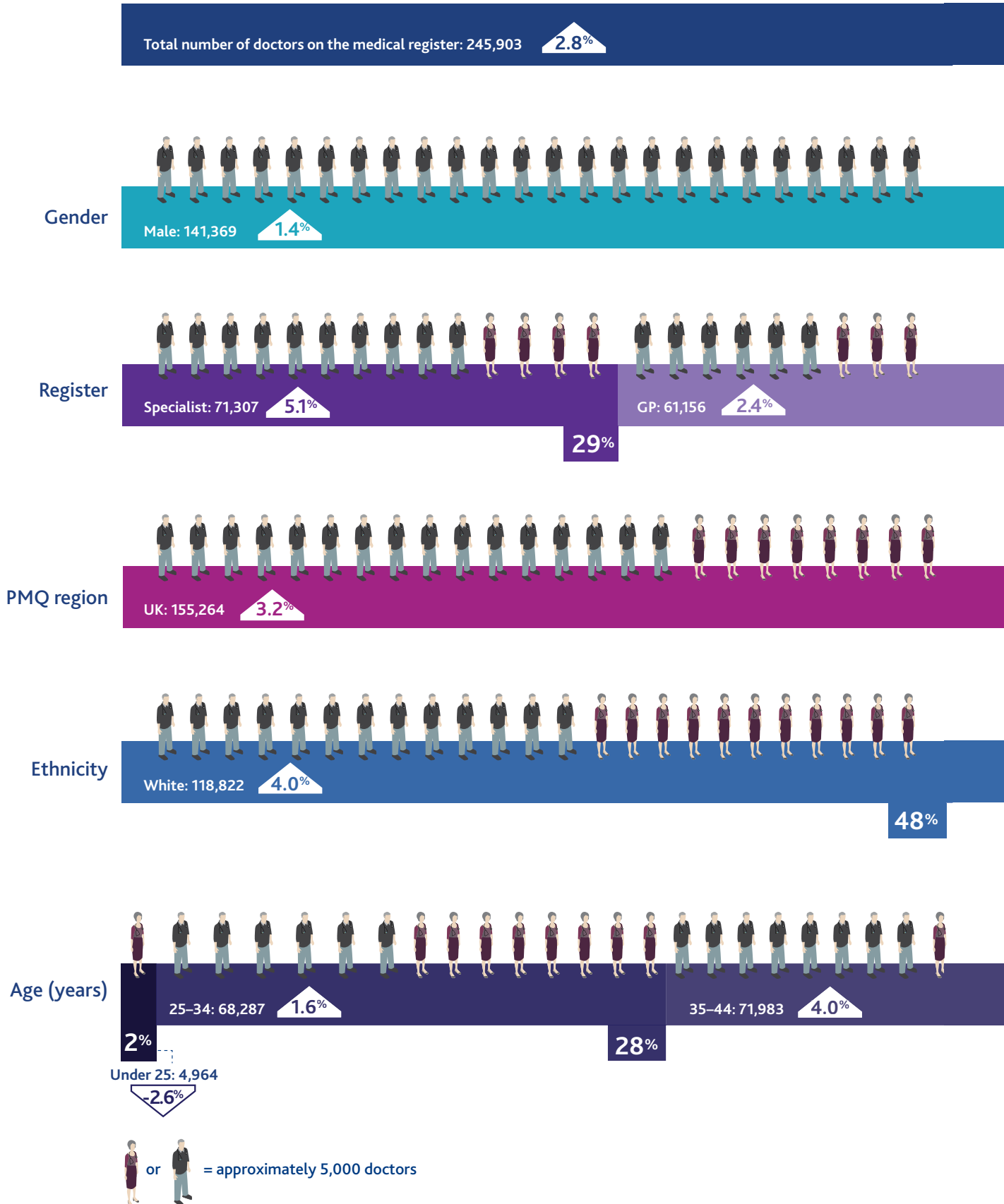
- 48% of registered doctors described themselves as white, 19% as Asian or Asian British, 2.8% as Black or Black British, 1.5% as mixed and 3.7% as other ethnic group.\* Ethnicity data are not available for 25% of doctors on the register.
    - For doctors who qualified in the UK, 62% described themselves as white and 14% as Black or minority ethnic (BME). We did not have ethnicity data for 24% of these doctors.
    - For doctors who qualified in the EEA, 67% described themselves as white and 8% as BME. We did not have ethnicity data for 25% of these doctors.
    - For doctors who qualified in the rest of the world, 10% described themselves as white and 63% as BME. We did not have ethnicity data for 27% of these doctors.
  - 71,307 doctors were listed on the Specialist Register, an increase of 3,464 from 2010.
    - 70% were men, 30% were women.
    - Of those listed, 68,068 were licensed.
  - The largest three specialties were anaesthetics, general psychiatry, and paediatrics, as in 2010. Paediatrics has moved from being the sixth largest to the third largest since 1996.
  - 61,156 doctors were listed on the GP Register, an increase of 1,418 from 2010.
    - 53% of doctors on the GP Register were men and 47% were women. This is a slight change from 2010, when the gender split of the GP Register was 54% men and 46% women.
    - Of those listed, 59,318 held a licence.
- Other groups of doctors included on the medical register were:
- specialty doctors (previously referred to as staff and associate specialist doctors)<sup>†</sup>
  - foundation doctors
  - specialty (including GP) postgraduate doctors in training
  - doctors who have not been entered onto the Specialist Register.

\* White includes white British, white Irish and other white. Asian includes Bangladeshi, Indian, Pakistani and other Asian. Black and Black British includes African, Caribbean, and other Black. Mixed includes white and Asian, white and Black African, white and Black Caribbean. These classifications are consistent with the ethnic categories used in the 2001 population census.

<sup>†</sup> In April 2008, the staff and associate specialist grades were amalgamated into one grade: the specialty doctor.

# Figure 1.1: Population of registered doctors in the UK in 2011

This figure shows the number of doctors in the UK register broken down by various characteristics and the change from 2010.



100%



Female: 104,534 **4.7%**

57%

43%

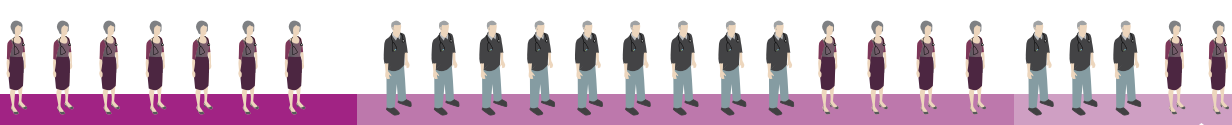


Doctors not on either register: 113,440\*

25%

\* This includes specialty doctors (formerly referred to as staff and associate specialist – SAS doctors), foundation doctors, specialty (including GP) postgraduate doctors in training, and doctors who have not been entered onto the Specialist Register.

46%



IMG: 66,608 **0.9%**

EEA: 24,031 **5.6%**

63%

27%

10%



Asian: 46,664 **4.3%**

Other: 9,002 **3.7%**

Black: 6,812 **2.8%**

Mixed: 3,643 **1.5%**

Not stated: 60,960 **-2.2%**

19%

25%

**5.7%** **7.5%** **8.1%**



45-54: 51,764 **3.9%**

55-64: 28,483 **3.9%**

65+: 12,360 **5%**

Unknown: 8,062 **3%**

29%

21%

12%

5%

3%

**4.8%** **-7.1%**

Doctor characteristics **%**

% change from 2010 figures ----

**%** ---- Proportion of the total register

### Medical education and training

- There were 41,268 medical students\* in the UK in 2011 (slightly lower than the 41,405 in 2010).
- 14,851 doctors were in the two-year Foundation Programme† (of whom 7,403 entered their first year in 2011 and were therefore provisionally registered). Doctors who are provisionally registered gain full registration with a licence to practise from the GMC after they have successfully completed their first year of foundation training.
- There were 40,991 doctors in specialist training. Of these, 9,650 were training to be GPs (24%) and 31,341 to be other specialists (76%).

## 1.2 Number of registered doctors

There has been a 2.8% increase in the number of doctors on the medical register since 2010. This is mirrored in the NHS workforce – for example, in England, there were 39,088 consultants in 2011, up 3.5% from 2010 and up 51.6% since 2001 (an average annual increase of 4.2%).<sup>80</sup> There were 39,780 GPs in 2011, up 0.9% from 2010, and 25% since 2001 (an average annual increase of 2.3%).<sup>81</sup>

The very large growth in the number of doctors reflects the significant rise in NHS funding over the past decade. It is not clear what impact there will be on doctor numbers and training opportunities as a result of the very different funding pattern now facing the NHS, but it seems unlikely that the level of growth will be maintained, at least in terms of the number of whole-time equivalent medical posts in the UK health services.

Despite the increases in recent years, it is worth noting that the UK is below the average for the OECD countries' ratio of doctors practising per 1,000 population. In 2009, the UK had 2.7 doctors per 1,000 population, compared with the OECD average of 3.1.<sup>82</sup> The UK also had fewer medical graduates than the OECD average – 9.3 per 100,000 population in the UK compared with 9.9, the OECD average.<sup>83</sup>

## 1.3 Gender

### The number and proportion of female doctors on the register continues to grow

Within the overall increase of registered doctors in the UK, the number of female doctors on the register has continued to grow at a faster rate than male doctors. During 2011, 6,549 female doctors gained GMC registration for the first time, with an overall increase of female doctors on the register of 4,645 (4.7%).

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\* This was the total number of medical students, according to the 2011 Medical School Annual Return (MSAR). The information returned by Newcastle Medical School did not include students studying medicine at its Malaysian campus.

† Entrants to foundation training will also have included doctors who completed their medical degree outside the UK. Some UK medical students go into further training outside the UK – for example, overseas students may elect to return to their home country for further training.

Whereas 5,714 male doctors gained GMC registration for the first time, with an overall increase of male doctors on the register of 1,988 (1.4%).

In 2011, for the first time, there were more than 100,000 female doctors on the register. The number of female doctors is expected to exceed that of male doctors between 2017 and 2022.<sup>84</sup>

### More flexible training and working patterns are needed

The growing proportion of female doctors may accelerate demands for more flexible working patterns, which will bring benefits for both male and female doctors.<sup>85</sup> There is some evidence that some specialties, particularly those with a higher proportion of female doctors in training, face some workforce difficulties. For example, the Royal College of Paediatrics and Child Health has reported problems in filling middle grade rotas, with consultant paediatricians increasingly having to cover middle grade duties as a result.<sup>86, 87, 88</sup>

Female doctors are underrepresented in certain specialties such as cardiology, gastroenterology,<sup>89</sup> anaesthetics and surgical specialties.<sup>90</sup> Working patterns can influence career choices. Certain specialties may be seen as more conducive to part-time working – for example, a study published in the *British Medical Journal* (BMJ) in 2009 showed that women who work part-time are overrepresented as GPs and underrepresented in other specialties, whereas women who had always worked full time were underrepresented in surgical specialties and general practice.<sup>91</sup>

As demands for more flexible working patterns increase, training and employers will need to accommodate shifting requirements, which would benefit both men and women. These could include less than full-time training and working, career breaks, maternity or paternity leave, and ensuring that returns to training and/or work are carefully managed. There may also be implications in terms of the number of medical student places required in the future, to ensure we are training enough doctors to meet future needs.

At the same time, demands are likely to make healthcare less of a nine-to-five weekday service and doctors at all stages in their careers may be expected to work outside those hours.

### There are differences in career progression between men and women

Differences in career progression for men and women have also been reported, although the much more significant difference appears to be linked to full or part time work. The study published in the BMJ in 2009 (previously discussed) followed 7,012 doctors, who were graduates of 1977, 1988 and 1993 from all UK medical schools. It found 96% of the male doctors from the three cohorts working in hospital practice became consultants, compared with 92% of the female doctors who worked full time, and 67% of the women working less than full time in hospitals. In general practice, across all three cohorts, again higher percentages of men than women reached general practice principal status. These differences were reduced, though, when comparing doctors working full time to those working part time.

Figure 1.2: Age profile of doctors on the register 2011

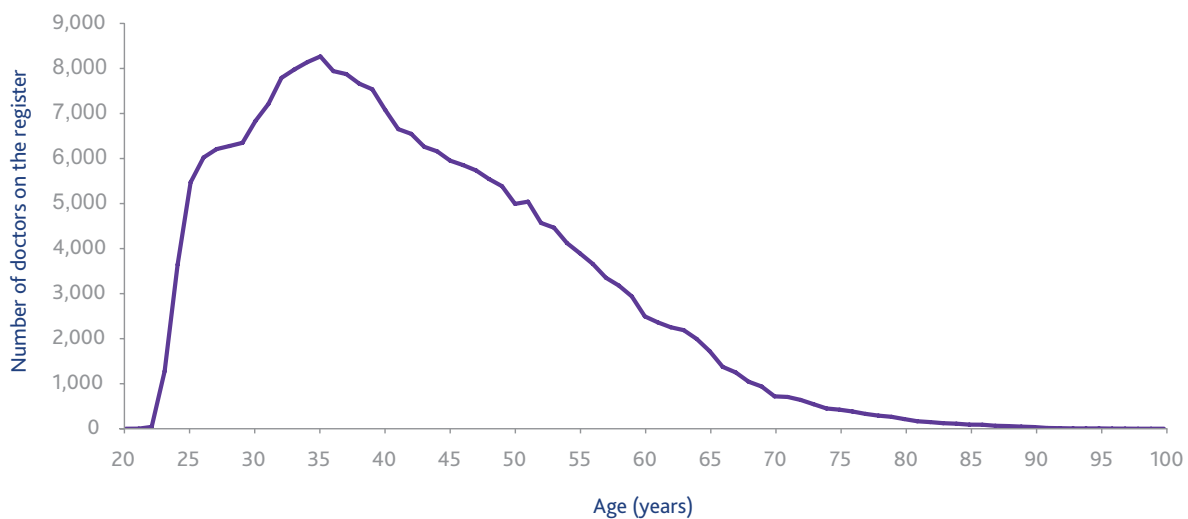
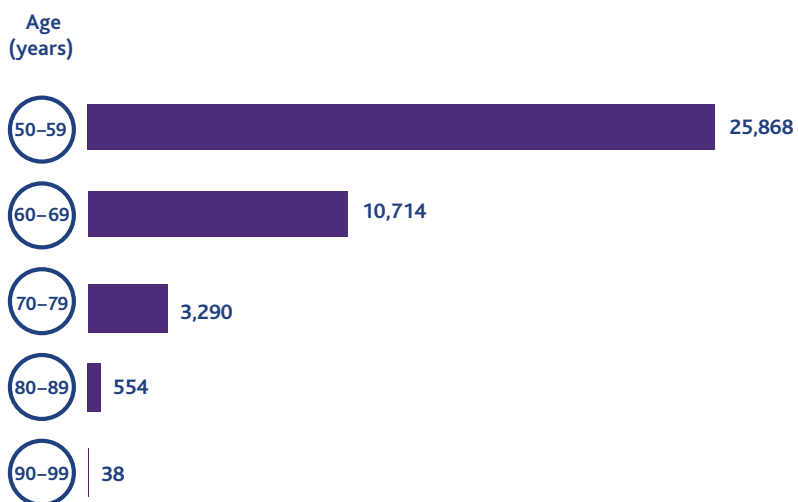


Figure 1.3: Registered doctors aged 50 years and over with a licence to practise in 2012



Principal status was attained by:

- 99% of men and 100% of women working full time with children
- 90% of men and 80% of women working part time with children
- 87% of men and 89% of women working part time with no children.<sup>92</sup>

As the number of female doctors on the register grows, working patterns and preferences may well change. At the same time, male doctors' expectations have changed. The changes in the profession point to the need for greater flexibility in both employment and training arrangements as well as an honest and open debate about what will and can be expected from doctors at different points in their careers.

## 1.4 Age

### A number of older doctors are choosing to remain registered and keep their licence to practise

The median age of registered doctors has risen slightly from last year from 39.8 to 39.9 years, with the mean also rising slightly from 42.3 to 42.4 years. The most common age for doctors in the UK (the mode) has risen from 34 to 35 in the last year. (See figure 1.2 on page 22.)

Following the introduction of licensing and the removal of the age exemption on the GMC annual retention fee in 2009, a large number of doctors

(63%) aged 65 and over left the register.<sup>93</sup> It is possible that the introduction of revalidation may have a similar impact on the age profile of licensed doctors on the UK register, as this will involve having regular appraisals to demonstrate their ongoing fitness to practise. We will monitor this as part of our planned evaluation of revalidation after it begins.

Although a large number of older doctors left the register during 2009, a significant cohort still remains with many maintaining a licence to practise. As shown in figure 1.3 on page 22, in 2011, there were 3,882 doctors aged 70 or over maintaining a licence to practise, with 592 of these aged 80 or over.

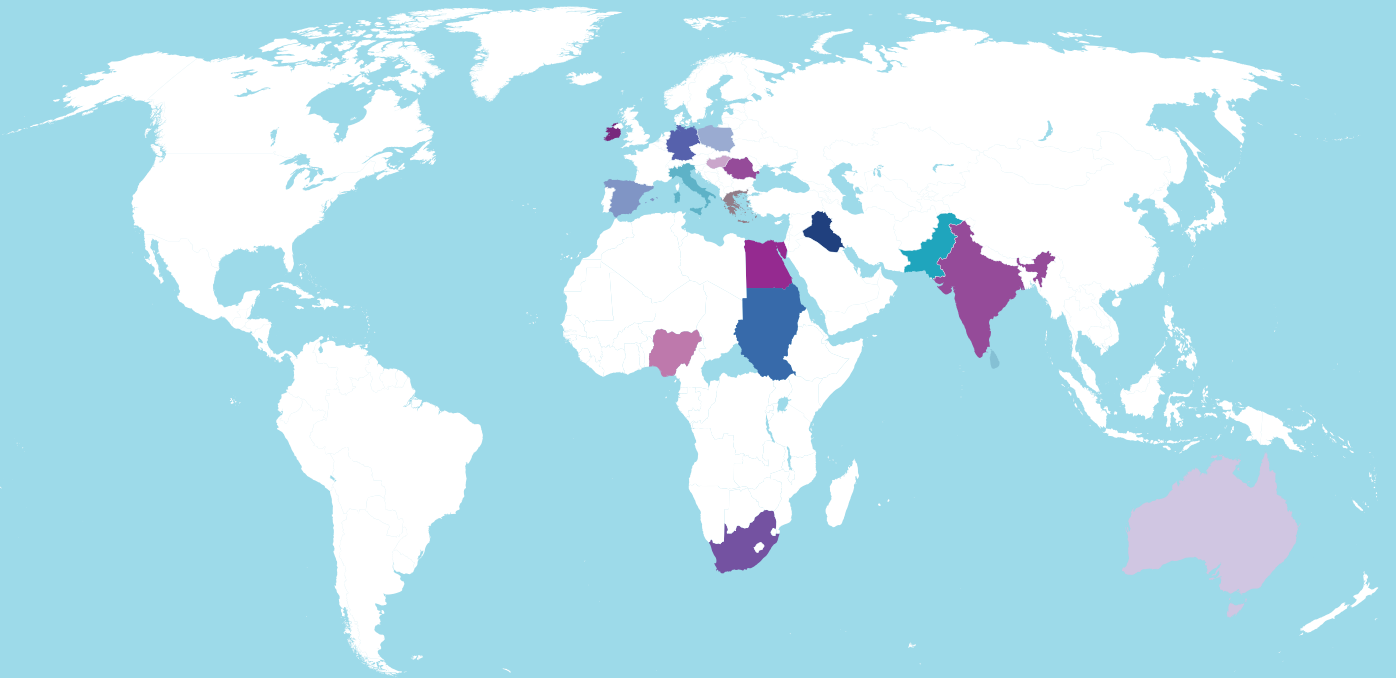
## 1.5 Place of primary medical qualification

More than a third of registered doctors qualified outside the UK. There is no doubt that the UK has relied heavily on the skill and dedication of doctors who were trained overseas. However, doctors who trained abroad can face difficulties when they start to practise in the UK, including unfamiliarity with health systems, communication and cultural differences, and lack of proficiency in English. We believe that these doctors may need greater support with adapting to UK practice than has previously been recognised.

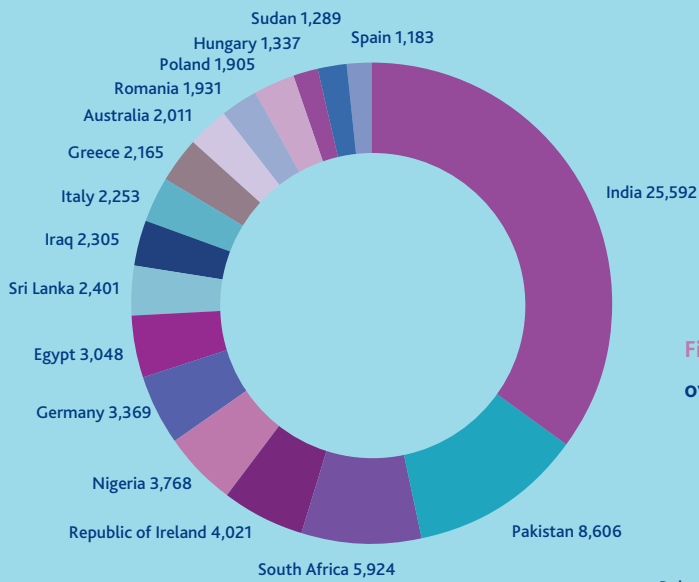
Figures 1.4–1.7 (see pages 24 and 25) show the top 17 countries where doctors registered in the UK gained their primary medical qualification.\*

\* These are countries with a minimum of 1,000 registered doctors as at 31 December 2011.

**Figure 1.4:** Countries with over 1,000 doctors on the register in 2011



**Figure 1.5:** Number of doctors from countries with over 1,000 doctors on the register in 2011



**Figure 1.6:** Doctors joining the register in 2011 (countries with over 1,000 doctors on the register)

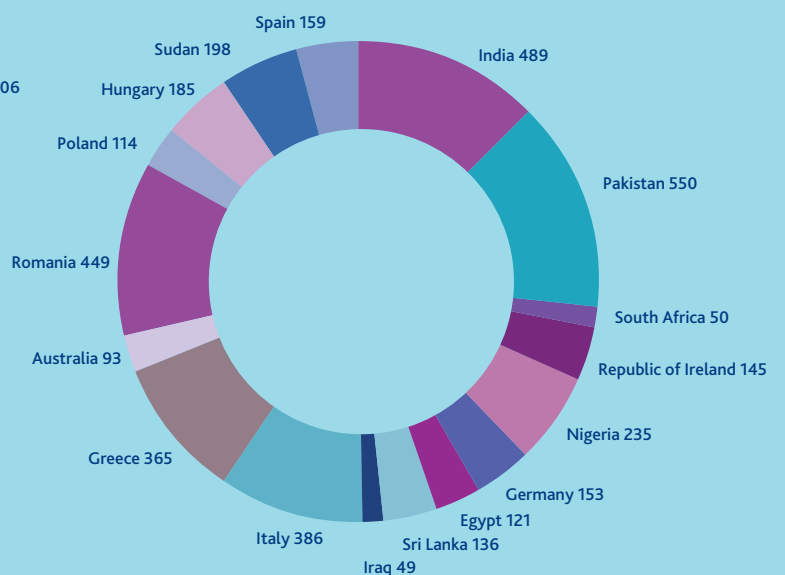
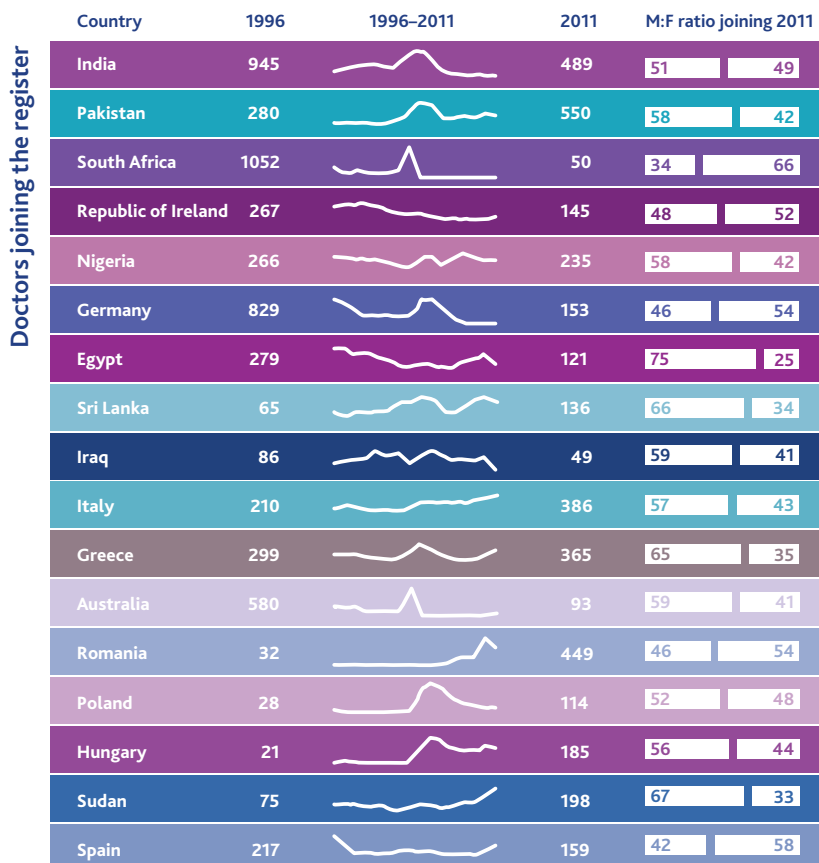
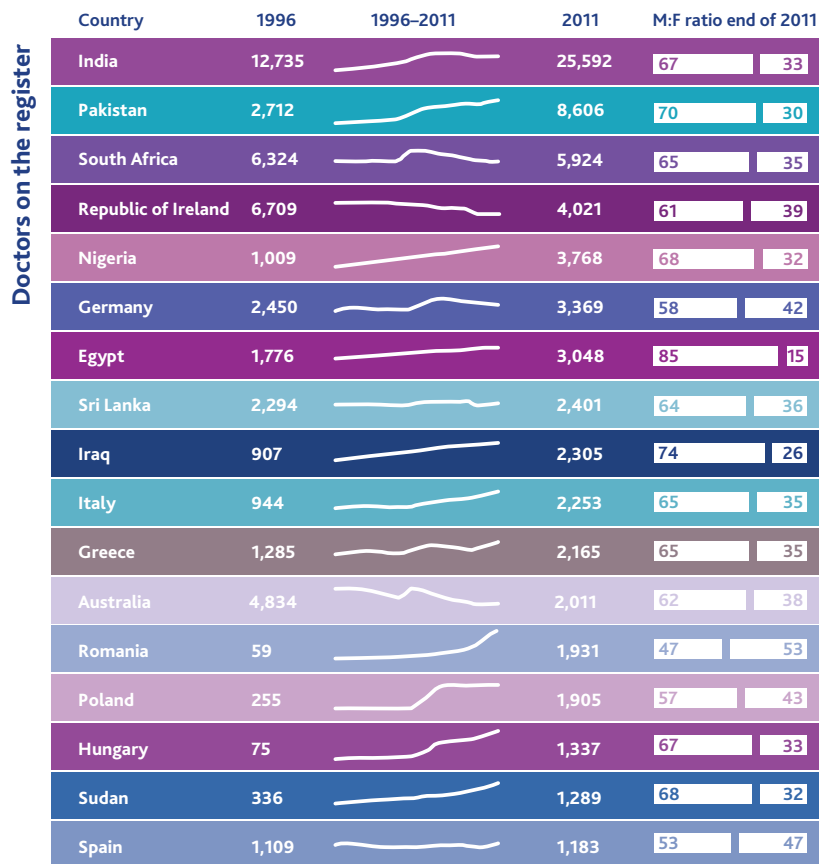


Figure 1.7: History of doctors joining the register for countries with over 1,000 doctors on the register in 2011



M=male, F=female.

The list of top 17 countries in 2011 has not changed since 2010. India continues to provide by far the largest number of overseas doctors, followed by Pakistan and South Africa. During 2011, the greatest number of doctors joining the register came from Pakistan (550), India (489), Romania (449), Italy (386) and Greece (365).

Looking at the trends over the past 15 years\* of doctors both on the register, and joining the register, gives a wider perspective, suggesting this map (figure 1.4 on page 24) will look different in the future. Some of the key trends and changes of the past 15 years are summarised below.

- Doctors with a primary medical qualification from India represent the largest group of overseas doctors on the register. However, the number of doctors coming from India has dropped from a peak of 3,641 in 2004 to current levels of around 500 a year. This may reflect changes in immigration rules in the UK, but may also be because the Indian Government is concerned that the country has a shortfall of up to 600,000 doctors.<sup>94</sup> Graduates who pursue higher studies in the USA now have to return to work in India for at least two years.<sup>95</sup>
- Doctors who qualified in Pakistan represent the second largest group of doctors on the register, with 8,606 at the end of 2011, and the largest number of doctors joining the register during 2011.

- The number of doctors joining the register from eastern European countries has risen significantly from 164 in 1996 to 1,120 in 2011, with a peak of 1,714 joining in 2005. This has led to an overall increase of doctors on the register who qualified in eastern Europe from 758 in 1996 to 8,581 in 2011. The increase reflects changes to the composition of the European Union<sup>†</sup> during this time.
- Doctors coming from South Africa declined from 1,052 in 1996 to 50 in 2011, with a large peak of 3,206 joining the register in 2003. After 2004, doctors with recognised qualifications from certain Commonwealth countries could no longer come straight onto the register with provisional or full registration. Doctors coming from Australia have followed a similar declining pattern with a peak of 2,105 doctors joining the register in 2003.
- Since 1996, the number of doctors on the UK register from most countries has increased. However, the numbers from Australia, Canada, Hong Kong, Republic of Ireland, Malaysia, the Netherlands, New Zealand, Singapore and South Africa have fallen.

The decline in doctors joining the register from some countries outside Europe is almost certain to have been affected by changes to visa and employment requirements. Since 2006, any NHS organisation

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\* The GMC started to collect electronic data in 1996.

† The EEA includes all countries of the European Union plus Iceland, Lichtenstein and Norway.

wanting to employ a doctor from outside the EEA has to prove that the post could not be filled by a doctor who qualified in the UK or the EEA.

As noted by the House of Commons Health Select Committee's report, *Education, training and workforce planning: first report of session 2012–13*, there is a need to ensure that effective workforce planning is in place to prevent over-reliance on doctors who qualified overseas. The report also suggested the need to protect against the 'poaching of clinicians from poorer countries' that have their own needs for well-trained clinical staff.<sup>96</sup>

Changes in the make-up of the UK's population of overseas qualified doctors point to the impact that external factors can have on the profession. This is illustrated by the case study in box 1, which looks at the recent increase in the number of registration applications from Greece and Spain.

Similar factors appear to be affecting some other nations. For example, in response to a survey the GMC undertook in May and June 2012,\* the German Medical Association reported increases in the number of doctors applying for registration from countries affected by political and economic unrest, including Syria, Iraq, Yemen and Greece.

### Box 1: The profession is affected by major international events

From 2010 to 2011, there were some notable increases in the number of doctors from Greece and Spain joining the UK medical register. Although these findings are perhaps unsurprising in view of the economic climate and high unemployment in both Greece and Spain, they highlight an interesting point about the globalised nature of the medical profession and how external factors can influence the make-up of the UK medical workforce.

From 2010 to 2011, there was a 29% increase in the number of doctors joining the register from Greece, up from 282 to 365. The number of doctors who registered in the UK from Spain for the first time increased by 28% from 124 to 159.

Since 2009, first-time registrations for doctors from Spain have risen by 96% and from Greece by 55%. The average increase of doctors joining the register for the first time from the EEA was 16%, compared with an overall increase of doctors joining the register for the first time of 4%.

\* We sent a survey questionnaire to the International Association of Medical Regulatory Authorities (IAMRA) and the European Network of Medical Competent Authorities (ENMCA), in which around 100 overseas regulators participated.

## 1.6 Medical education and training

### Medical students continue to come from higher socioeconomic groups

Although there is greater diversity in the medical profession than there has been before, most medical students continue to come from higher socioeconomic backgrounds. As noted in the recent report on fair access to professional careers, chaired by Alan Milburn, of the 2010–11 undergraduate medical schools' intake, 57% came from the top three socioeconomic groups, and 7% from the bottom three.<sup>97</sup>

The reasons behind this are complex and varied: they may include expectations and results from secondary education, high competition for places and a high academic bar. Medical schools have put in place a number of widening access initiatives to encourage applications from young people from less advantaged backgrounds, and further work is needed to understand the impact these have had.<sup>98</sup> The GMC has commissioned a literature review to identify best practice in the selection of medical students, including the effectiveness of initiatives to promote fair access. The final report is expected by the end of 2012. Along with the Medical Schools Council, the GMC will undertake a joint programme of work on student selection and fair access to spread best practice.<sup>99</sup>

As well as understanding how socioeconomic background affects entry to the profession, we and others also need to understand better how it might affect career progression, and whether any differences might exist in the positions doctors hold. This includes ensuring that there is more systematic

collection and publication of information on the social backgrounds of staff in the medical sector.<sup>100</sup>

### There are concerns about demand for foundation training and consultant posts

As the number of doctors on the register continues to grow, there is an ongoing debate about a potential oversupply of doctors in the future and the career opportunities that will be available to them.

First, there is now considerable concern that there will not be enough foundation places for students emerging from UK medical schools. This has been caused by a range of factors, including reported unintentional over-recruitment to some medical schools, and the influx of students from the EEA, and others with a right to work in the UK. Although medical school numbers are not a matter for the GMC, we have stated before that students who enter UK medical schools under the current arrangements have a legitimate expectation that, if they pass their examinations and graduate, they should have the opportunity to qualify as a doctor. To do this, they need to enter the Foundation Programme and complete the first year of foundation training, which allows them to become fully registered with the GMC. There is now an urgent need to find a solution, both in the short and in the long term to this issue, and it is incumbent on all of us with an interest in this area to contribute to finding it. The Health Education National Strategic Exchange, a national forum for senior members of the higher education and health sector, has commissioned the Centre for Workforce Intelligence (CfWI) to undertake analysis to inform its review of provision of medical and dental training numbers.

Debate also continues about the potential size of the future consultant workforce. In a recent report, the CfWI in England estimated that, based on current trends, and assuming that all eligible doctors become consultants within the current grade structures and terms and conditions, the number of fully trained hospital doctors will increase by over 60% to 60,000 by 2020.<sup>101</sup> The result would be an estimated £6 billion annual spend on consultant salary costs, an increase of £2.2 billion on the 2010 spend. These figures are not projections on the medical workforce that the health service might need, but predictions based on the current shape of the workforce.

The assumption that the consultant workforce will increase by 60% is based on headcount data rather than full-time equivalents.<sup>102</sup> Therefore this does not take into account a possible rise in less than full-time working across the profession, which could reduce the predicted oversupply.

### There is a continuing debate about the distribution of doctors across medical specialties

There is an increasing awareness that the specialties in which doctors choose to train and work do not correspond with those with the greatest patient need. The ageing population and the associated increase in complex long-term conditions and comorbidities will put greater pressure on primary care. Increasingly, GPs will have a critical role to play in coordinating care for their patients across a number of services, in both health and social care.<sup>103</sup>

This poses questions about the appropriate balance between specialists and generalists – specifically whether we have enough GPs to meet the needs of the changing patient demographics. There is a related question of whether the current system of narrowly defined medical specialties is sufficiently aligned to society's changing healthcare needs.<sup>104</sup>

The independent review of the Shape of Training,\* established in 2012, will help to consider these questions in more detail. The review aims to ensure that doctors receive high quality training that supports patient outcomes. A key theme is to consider whether we have the right balance between specialists and generalists to deliver appropriate care both now and in the future. Building on previous reviews by the Postgraduate Medical Education and Training Board (PMETB),<sup>105</sup> Collins<sup>106</sup> and Tooke,<sup>107</sup> the review will also consider the breadth and scope of training, and how doctors in training can be better supported in gaining the right mix of knowledge, skills and behaviours to prepare for the different environments and contexts in which care is provided.<sup>108</sup>

The review will also examine how current training structures could be made more flexible – for example, enabling doctors in training to move between specialties more easily once they have entered higher specialty training. This will be essential both in ensuring that the workforce can respond to changing patient demand and in accommodating changing career choices of individual doctors in training.

\* This is an independent review chaired by Professor David Greenaway, which is jointly sponsored by the Academy of Medical Royal Colleges, the General Medical Council, Medical Education England, the Medical Schools Council, NHS Scotland, NHS Wales and the Northern Ireland Department of Health, Social Services and Public Safety. The review will look at potential reforms to the structure of postgraduate medical education and training across the UK. Its aims are to ensure that postgraduate education continues to train effective doctors who are fit to practise in the UK, who provide high quality and safe care, and who are equipped to meet the needs of patients and service now and in the future. The final report of the review is expected next year.

## Section 2: Complaints about doctors

The GMC's statutory role is to protect patients and to promote and maintain their health and safety by making sure doctors working in the UK practise medicine safely and to the standards we set. We do this in part by investigating complaints made to us about doctors and deciding what action, if any, is needed to protect patients. (See box 2 on page 31.) In the most serious cases, we can remove a doctor's right to practise medicine altogether.

The GMC is just one organisation dealing with complaints about doctors, and often it is only the most serious complaints that come to us. We need to be careful not to draw too many conclusions from the relatively small number of very serious cases brought to our attention. Nevertheless, our data give us a useful insight into where things are going wrong, and there are aspects of these data that merit discussion and further analysis.

## Box 2: The fitness to practise process

### Triage

Every complaint is subject to an initial assessment by the GMC (triage). This is to determine if the information raises a question about a doctor's fitness to practise that requires investigation. This could be either by the GMC or it could be more appropriate and proportionate for them to be considered locally, by the organisation concerned, in the first instance.

If for any reason the complaint does not fall within our remit, it will be closed and the complainant informed that the GMC will not be taking any action. In some instances, the GMC can refer the complainant to another, more appropriate, regulator, or offer advice on the steps that the complainant may wish to consider.

### Stream 2

If the information would not require us to take action, but may do so if it were part of a wider pattern of behaviour or practice, the GMC will contact the doctor's employers to ask for further information about the doctor's practice. We then make a decision about whether there needs to be a full investigation.

### Stream 1

If a complaint raises serious concerns, we carry out an immediate investigation. This may include an assessment of a doctor's health or performance or obtaining an expert report and then referring the findings to staff employed as decision makers. There are five possible outcomes at this stage, the most serious being referral to a fitness to practise panel hearing.

If the case is referred to a fitness to practise panel hearing, the panel has three tasks. It has to decide:

- if the facts are proven
- if the doctor's fitness to practise is impaired
- what the appropriate outcome should be.

There are eight possible outcomes at the panel stage – the most serious being erasure from the medical register, which means the individual cannot work as a doctor in the UK.

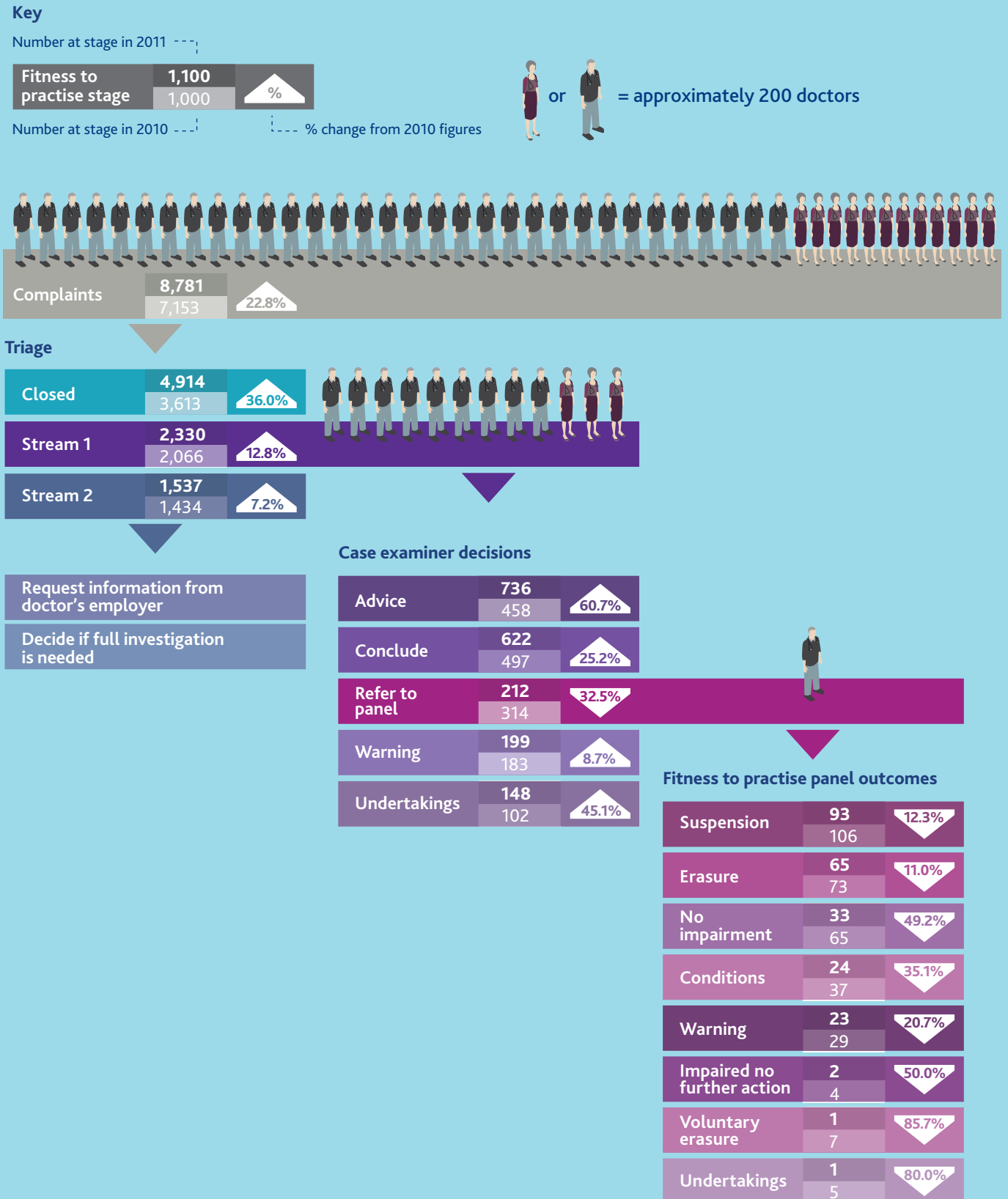
If the GMC believes it is in the interest either of the public or of a doctor for their practise to be restricted in some way while the allegations are investigated, the case will be referred to the interim orders panel. The panel will make an immediate decision and any restrictions imposed will remain in place until the case is completed.

### Complaints and allegations

Analysis in this report makes reference to 'complaints' and 'allegations'.

- **Complaints** are defined as information received by the GMC that may raise concerns about a doctor's fitness to practise. They may come from a member of the public, an employer or another public body.
- **Allegations** are attached to any complaint that goes forward to be investigated. They describe the nature of the concern about the doctor's fitness to practise. Many cases involve more than one allegation.

Figure 1.8: Number of doctors in the GMC's fitness to practise processes in 2011



## 2.1 Complaints in 2011

- We received 8,781 complaints in 2011, up 23% from 7,153 in 2010. This is a significant rise, and continues an upwards trend since 2007.
  - 5,665 complaints came from members of the public, an increase of 25% from 2010.
  - 1,481 complaints came from individuals working for public bodies, such as police officers, coroners and medical directors. This was an increase of 6% from 2010.
  - 1,635 complaints came from the 'Other' category, which includes complaints from other doctors and other healthcare professionals as well as investigations initiated by the GMC. This was an increase of 33% from 2010.
- We closed 4,914 complaints (56%) at initial assessment because they did not raise an issue about a doctor's fitness to practise. This is up from 2010, when we closed 50% or 3,613. We saw an increase in complaints about issues that do not fall under our remit, for example the side effects of treatment, requests for interventions in treatment or conflicting diagnoses.
- We completed 3,465 investigations, involving a total of 9,282 allegations.\*
  - We made preliminary enquiries with employers to check for wider concerns in relation to 1,537 (17.5%) complaints (stream 2). This was down from 21% in 2010.
  - We conducted a full investigation about 2,330 complaints (26.5%) in stream 1. Although the number of these complaints rose, the proportion of the total fell from 29% in 2010.
- We suspended 93 doctors, down from 106 in 2010. However, as a proportion of hearing outcomes this was up from 33% in 2010 to 38% in 2011 due to the drop in the total number of hearings. Two of these cases related to doctors where there was a concern that health issues were adversely impacting on their practice, but there were no other concerns about their fitness to practise. Under current legislation, we cannot erase doctors where there is a concern solely relating to their health.

\* We classify the concerns raised about doctors into eight main categories, seven of which correspond to the chapters of *Good Medical Practice*. Each of these categories covers a range of different allegations that can be raised about a doctor's practice. We will soon be publishing a revised version of *Good Medical Practice*, which will contain slightly different domains from the seven listed in box 3 on page 40 of this report. Next year, our reporting may reflect the revised version.

- We erased 65 doctors from the register, compared to 73 in 2010. The proportion of erasures to the total number of hearing outcomes actually went up, from 22% to 27%. In 2011, the allegations that were most often involved in cases leading to a doctor being struck off the register included: substandard treatment, financial deception, false and misleading reporting, incomplete medical records, failure to cooperate with an investigation and fraud. Often allegations are one part of a broader case of allegations being investigated or considered by a fitness to practise panel. Panels can consider more than one allegation for a case. The most serious sanction would be applied to the whole case.

## 2.2 Volume of complaints

### Complaints about doctors have continued to rise

The number of complaints received by the GMC about doctors has risen by 23% since 2010, which continues an upwards trend since 2007. (See figure 1.9 on page 35.)

Between 2009 and 2010, there was a 24% rise in complaints received. Last year's increase was 23%, and data for the first part of 2012 suggest a similar pattern with a rise of 27% by the end of July 2012 (year to date). Rising patient expectations and an increased willingness to complain have been cited as possible reasons for this rise, and recent evidence points to a wider increase in litigation claims against the NHS in England.<sup>109</sup>

Although many complaints do not meet our criteria for investigation, the large rise in overall complaints has resulted in more doctors being investigated. One doctor in 64 was investigated in 2011 compared with one in 68 in 2010.\* Over a working career, this means that a doctor has a significant chance of being complained about and being investigated by the GMC. This raises questions about the relationship between the GMC and the profession, and makes it more important than ever that the right cases are investigated and that we protect patients by dealing with complaints effectively and efficiently.

### Complaints about doctors have also risen outside the UK

We surveyed a number of European and international medical regulators<sup>†</sup> to assess if they had seen a comparable increase in the number of complaints made about doctors.

Medical regulators in Belgium and Denmark both reported a notable increase in the number of complaints received. Complaints in Belgium have increased by 22% since 2007 and in Denmark by 88% from 2007 to 2010. In New Zealand, although the number of overall complaints was much smaller, there was a sizable rise in complaints, from 66 in 2010 to 182 in 2011. And in the USA, there was a 7% increase in state medical boards taking disciplinary action against doctors between 2010 and 2011.<sup>110</sup> Possible reasons have been put forward for this increase, including better training for investigators so they can prepare better cases and patients' increased awareness of how to complain.<sup>111</sup>

\* In last year's report we rounded up the figure of one in 68 to one in 70: see *The state of medical education and practice in the UK: 2011* p70.

† We sent a survey questionnaire to the International Association of Medical Regulatory Authorities (IAMRA) and the European Network of Medical Competent Authorities (ENMCA), in which around 100 overseas regulators participated.

Figure 1.9: Number of complaints received by the GMC (2007–11)

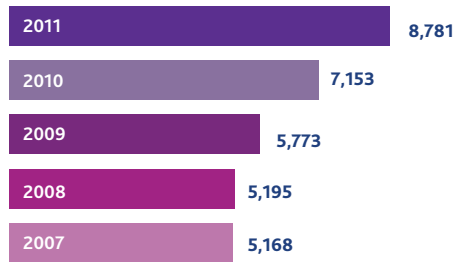
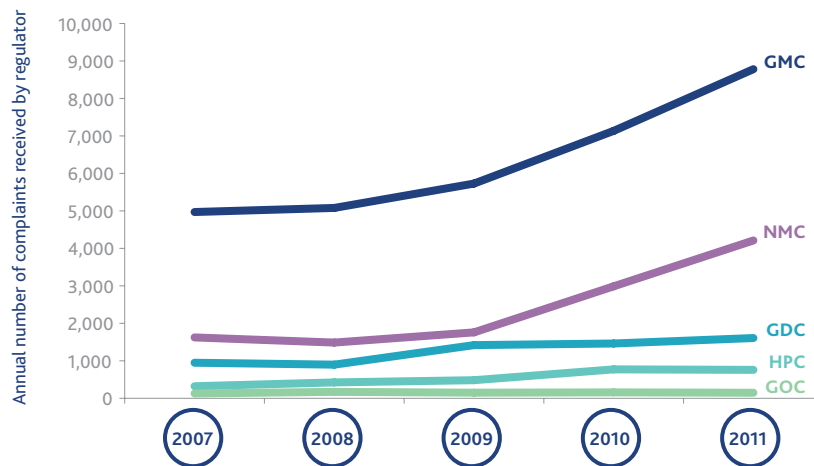


Figure 1.10: Number of complaints\* to UK health professional regulators (2007–11)



\* 'Complaints' in this context are the same as 'referrals' to other regulators.

### Complaints across the NHS have also risen

In considering why complaints about doctors have risen, it is important to examine trends in health complaints more broadly.

In England and Scotland, there was little change in the number of written complaints about hospital and community services and primary care services from 2009–10 to 2010–11.<sup>\*,112,113</sup> In Wales, there was a 13% rise in complaints about hospital services from 2009–10 to 2010–11, and a 7% increase in complaints about primary care services.<sup>114</sup> In Northern Ireland, there was a 7% increase in complaints about hospital and community services, but complaints about GPs changed only marginally.<sup>115</sup> Complaints to the Health Service Ombudsman in each of the four countries showed a similar pattern.<sup>116,117,118,119</sup>

### Complaints about other health professions have also risen, but doctors are more complained about than others

While most other professional regulators have seen a rise in complaints since 2007, both in absolute terms and relative to register size, the GMC received a higher number of complaints than the

General Dental Council (GDC), the General Optical Council (GOC), the Nursing and Midwifery Council (NMC) and the Health Professions Council (HPC).<sup>†</sup> (See figure 1.10 on page 35.)

NHS complaints data also reflect this rise in complaints about doctors. Since 2006, there has been a rise in NHS written complaints about doctors working in both hospital and community services, and in general practice.

In England<sup>120</sup> and Wales,<sup>121</sup> NHS complaints specifically about doctors exceeded those for other staff groups, including nurses, midwives and health visitors, which as a collective group is larger in size than the medical profession. This could be because doctors are required to take higher-risk decisions, and are seen as the focal point for planning a patient's care. In Scotland, however, complaints about nurses exceeded those about doctors.<sup>122</sup> Comparable data were not available for Northern Ireland.

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\* In England, from 2009–10 to 2010–11, there was a reported 2.4% decrease in complaints for hospital and community services, and a 0.3% decrease in complaints about primary care services. In Scotland, complaints about hospital and community services declined very slightly by 0.9% from 2009–10 to 2010–11, whereas complaints about GPs rose marginally, by 1.4% in the same time period.

† We requested data on the number of complaints received from those UK health professional regulators with a minimum of 10,000 registrants. These include the GDC, the GOC, the General Pharmaceutical Council (GPC), the HPC and the NMC. The GPC was only able to provide data for 2011, as it assumed responsibility for regulation of pharmaceutical services on 27 September 2010. There were 809 complaints to the GPC in 2011.

## 2.3 Who complained?

### Most complaints come from the public

Most complaints came from members of the public, accounting for 64% of the total (5,665). This was an increase of 25% from 2010. (See figure 1.11 on page 38.) Complaints about some issues have increased above the average rise in complaints. These have tended to be the issues that patients are more likely to complain about. (See section 2.5 on page 40.) Some of these complaints might have been through a local process before coming to us.

Complaints from individuals working for public bodies, such as police officers, coroners and medical directors (persons acting in a public capacity – PAPC), accounted for 17% of all complaints we received in 2011. In recent years, complaints from official bodies have gradually increased as a proportion of complaints received by the GMC, accounting for 10%\* in 2007 up to 20% in 2010.

In 2011, 1,635, or 18% of complaints came from other sources, including complaints from other doctors and other healthcare professionals as well as investigations initiated by the GMC. These types of cases rose by 33% compared with 2010, partly because of a significant increase in issues identified by the GMC in media coverage and partly because of referrals from public organisations such as patient groups and professional organisations.

In absolute terms, complaints from members of the public have increased more than from any other source. A large proportion of these complaints are not taken forward for investigation by the GMC because, while they may raise an issue about the patient's experience, they do not raise an issue about a doctor's fitness to practise. In many cases, these complaints are best dealt with at a local level, where issues can be directly tackled with healthcare providers.

Later this year, the GMC will commission further research into why more complaints are being made to the GMC across the UK. Specifically, this will aim to understand the increase in complaints from members of the public and in those complaints that are closed at the early stages of our fitness to practise procedures.

\* The GMC classification of referrals was changed in 2009. If this classification is applied to 2007 data then the rise is approximately 14% in 2007 to 20% in 2010.

Figure 1.11: Number of complaints received by the GMC by source of referral (2007–11)\*

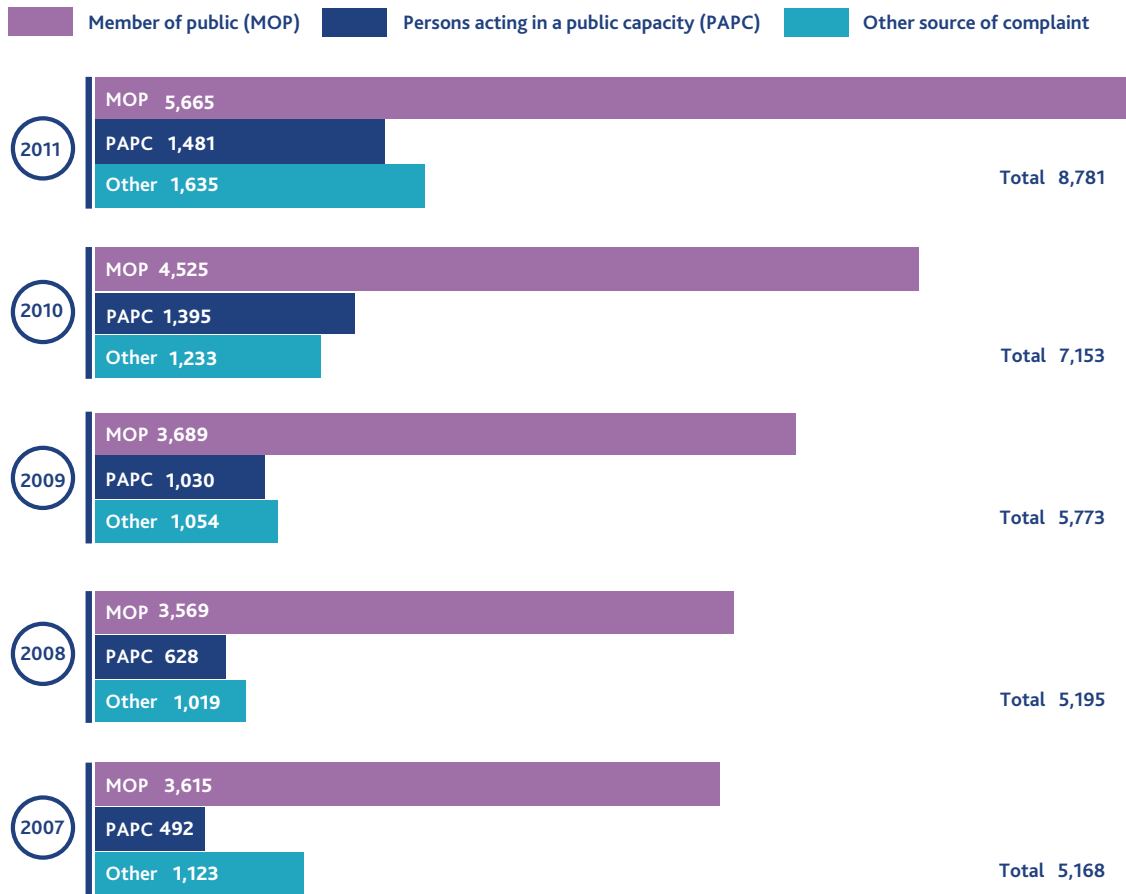
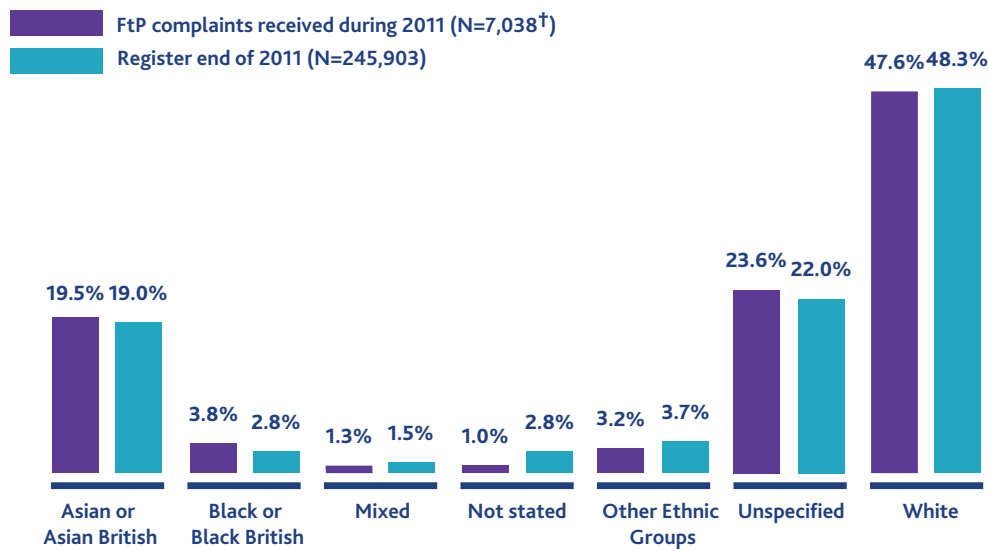


Figure 1.12: Distribution of complaints received by the GMC relative to the distribution of ethnic groups on the medical register in 2011



\* The methodology for classification of referrals was changed in 2009. Therefore referrals from some sources (such as internally by the GMC) may have been classified differently in 2007 and 2008.

† Not a complete data set of all complaints received by the GMC in 2011 as around 19% of complaints are in respect of doctors who are not identified.

## 2.4 Who did complaints tend to be about?

### Certain groups are overrepresented in complaints to the GMC

Almost three-quarters (73%) of all complaints in 2011 were about male doctors, though only 57% of all registered doctors were men.

General practice, psychiatry and surgery were overrepresented as specialties. 47% of all complaints were made against GPs, who represented 24% of the register. This is not surprising given the large number of interactions GPs have with their patients.

8% of complaints were made against psychiatrists, who represented 3.5% of the register. Surgeons received 11% of complaints, compared with their representation on the register of 5%.

In 2011, older doctors were more likely to be the subject of a complaint to the GMC, with doctors who qualified 20 years ago or longer being overrepresented in complaints relative to their representation on the register.

Based on the data we hold,\* there is no evidence that ethnicity plays a role in the likelihood of a doctor being complained about to the GMC. (See figure 1.12 on page 38.)

### The same groups are overrepresented in NCAS data

Data on referrals to the National Clinical Assessment Service (NCAS)<sup>†, ‡</sup> showed very similar trends to complaints made to the GMC.

- Doctors working in certain specialties were more likely to be referred to NCAS than others; notably, psychiatry, obstetrics and gynaecology, and general practice.<sup>123</sup>
- Referrals were substantially greater for men than for women. Female doctors were also shown to be significantly less likely to be suspended or excluded from work.<sup>124</sup>
- BME doctors who qualified in the UK were not overrepresented in referrals to NCAS, or in suspensions or exclusions.
- However, non-white doctors who qualified overseas were more likely to be referred to NCAS.<sup>125</sup> In chapter 2, we consider how the place of primary medical qualification might affect the likelihood of a doctor being complained about.

In this year's report, we look at what might drive these patterns of complaints. In chapter 2, we compare the different types of complaint made about different groups of doctors. In chapter 3, we then consider what impact the environment might have on doctors' practice.

\* We only have ethnicity data for 75% of doctors on the register.

† NCAS provides support to healthcare organisations and individual practitioners in England, Northern Ireland and Wales to resolve performance concerns about doctors, dentists and pharmacists. It makes recommendations to support their return to safe practice.

‡ Based on referrals to NCAS between 2001 and 2009.

## 2.5 What did people complain about?

The GMC classifies the complaints it takes forward for investigation (allegations) into eight main categories, seven of which correspond to the chapters of *Good Medical Practice*. Each of these categories covers a range of different concerns that can be raised about a doctor's practice. (See box 3 below.)

This section draws on data relating to allegations that the GMC investigated. As explained in box 2 on page 31, these do not include complaints that were closed on initial assessment, and a complaint may result in more than one allegation.

In 2011, the three most prevalent types of allegations the GMC investigated were the same as in 2010: investigations or treatment (2,643), effective communication (789), and respect for patients (679). (See figure 1.13 on page 41.)

### Box 3: Allegation categories

- **Clinical care:** investigations or treatment, record-keeping, patient assessment, patient examination, use of resources, treatment in emergencies, consulting colleagues, recognising limits of personal competence
- **Probity:** criminal conviction, conduct, financial and commercial dealings with patients, conflicts of interest, writing and signing reports and documents, informing the GMC of charges or offences
- **Relationships with patients:** effective communication, respect for patients, treating patients with dignity, consideration for family and carers; confidentiality, being open and honest if things go wrong
- **Working with colleagues:** working in teams, respect for colleagues, sharing information, reporting concerns about colleagues
- **Health:** mental and behavioural illness, physical illness, adapting practice when ill
- **Maintaining good medical practice:** keeping up to date, maintaining and improving performance
- **Teaching or supervision:** honest assessment and appraisal, appropriate supervision, references and reports, appropriate audit and peer review
- **Compliance with GMC investigations:** failure to comply with assessment

Figure 1.13: Top three types of allegations investigated by the GMC in 2011: specific concerns raised



### The number of cases about how doctors interact with their patients has increased

In 2011, allegations investigated about effective communication increased by 69% and allegations about respect for patients rose by 45% (compared with a 24% increase in allegations investigated overall). Unsurprisingly, these issues about doctors' interactions with their patients tend to be the things that patients are more likely to complain about. (See figure 1.14 on page 43.)

Several factors may have contributed to this increase. There is no evidence that it reflects a deterioration in doctors' ability to communicate – instead they may reflect rising patient expectations and better informed patients who have access to a greater range of information (particularly online).<sup>126</sup> Other factors such as greater equality in modern society have also influenced people's relationships with professionals, including the patient-doctor relationship and what patients expect from it.<sup>127</sup>

As the NHS Constitution makes clear, the NHS and the doctors who work in the NHS have a duty to every individual they serve and must respect their human rights, which means treating patients with dignity, respect, compassion and kindness.<sup>128</sup> Our core guidance for doctors, *Good Medical Practice*, also stresses this duty.<sup>129</sup>

It is important to acknowledge that the number of allegations investigated are very small when set alongside the huge number of doctor-patient interactions that take place every day. (See box 4 below.)

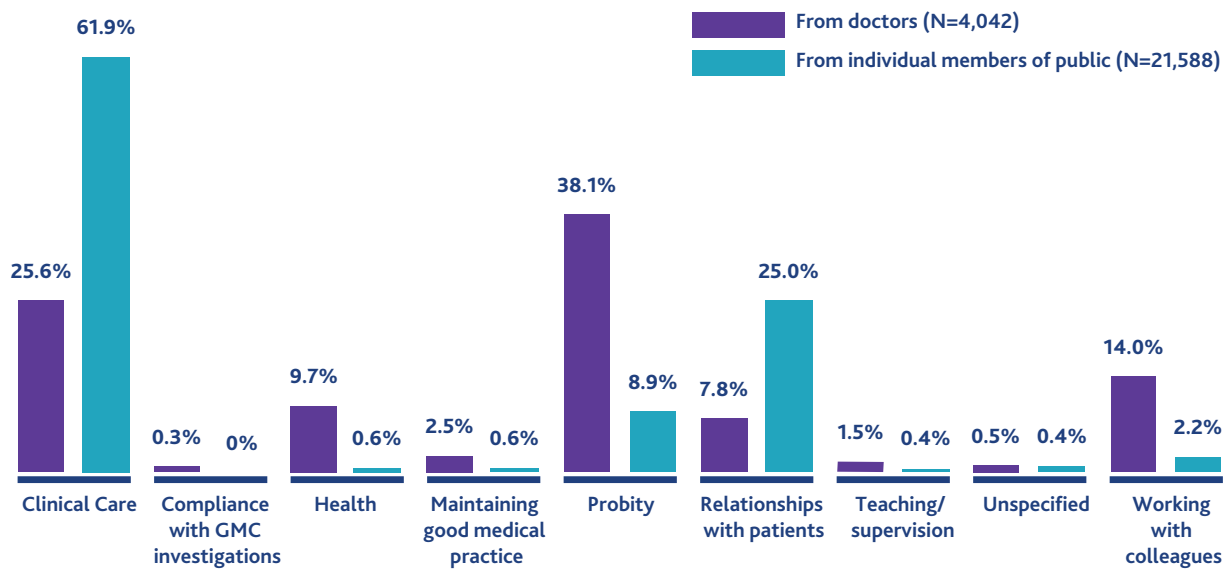
#### Box 4: Number of patient contacts in the NHS in England May 2011–April 2012\*

- 17.5 million inpatient appointments<sup>130</sup>
- 73.1 million outpatient appointments<sup>131</sup>
- 17.6 million accident and emergency attendances<sup>132</sup>

And, on an average day, the NHS has more than a million patient encounters in general practice.<sup>133</sup>

\* Figures published on HES online on 30 August 2012.

Figure 1.14: Comparison of distribution of allegations investigated by source of complaint (2007–11)



### Providing patients with full information and listening are central parts of good medical practice

Providing patients with full information, including all clinically appropriate treatment options, is a crucial element of care, which can impact greatly on both patient experience and outcomes.<sup>134</sup>

Our data showed that certain allegations involving communication rose substantially in 2011 (see box 5 opposite).

While the number of allegations investigated about communication issues is relatively small, the fact that the number has increased markedly since last year is important. This is something that we and others need to reflect on and in particular to understand whether it raises issues about how doctors interact with their patients. And, since complaints are often made locally before being made to the GMC, allegations we investigate are likely to represent a wider concern from patients about how their doctors communicate with them.

#### Box 5: Increases in allegations investigated about doctors' communication skills in 2011

- Allegations investigated about rudeness to patients increased by 39% to 379 cases.
- Allegations investigated about failing to respond to concerns increased by 64% to 208 cases. This included issues such as a doctor failing to respond appropriately or quickly enough to a concern raised by a patient, acting rudely or with a lack of sympathy in response to a patient having raised a concern.
- Allegations investigated about failing to provide appropriate information also increased by 64% to 195 cases. This tended to concern the failure to explain the risks or possible side effects of treatment, giving incorrect information and failing to explain all possible available treatments, and also failing to explain correctly processes or pass on results.

Research evidence has also pointed to the importance of giving patients information about all available clinically appropriate care options. Failure to do this was described in a recent report from The King's Fund as the 'silent misdiagnosis'.<sup>135</sup> The report points to a range of international evidence on the impact of information in patient decision making. This evidence included a study of major elective surgeries, which showed that demand for surgical intervention decreased by 20% after patients became well informed.<sup>136</sup>

The King's Fund report also noted examples where there had been a major mismatch between doctors' and patients' perceived preferred outcomes. In breast cancer, for example, doctors believe 71% of their patients rate keeping their breast as a top priority, when in fact this was the case for 7% of patients.<sup>137, \*</sup> Studies of this kind underline the importance of open discussions with patients, providing them with clear information, and listening to what they want.

Research commissioned by the GMC into factors that encourage or discourage doctors from following good practice similarly reported that doctors' perceptions of the needs of particular patient groups, and what care may be appropriate for them, might be very different from patients' actual needs and concerns. And it noted that this may be more relevant to particular patient groups – for example, older people and people with learning disabilities.<sup>138</sup>

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\* The report does not make clear whether patients answered this question before or after surgery.

## Conclusion

The composition of the UK's medical profession continues to change, as do the demands placed upon it. Major changes include the proportion and number of women doctors, the age of doctors and where in the world they trained. Our findings suggest that a new workforce model is needed to take account of these.

### **Changing lifestyles and expectations of doctors mean that the need for flexible working and training is becoming increasingly important.**

A third of doctors practising in the UK qualified overseas. This year's report shows how global events can impact on the make-up of the UK medical profession. Taken over a long period of time, geopolitical changes of the sort we have seen in Europe, and the rise of rapidly developing nations, can have a big impact on our workforce. As the profile of our doctors changes, we need to ensure we adapt how we communicate, and instil the standards expected in UK practice in all doctors, regardless of where they trained.

As part of the debate about a changing workforce, we are increasingly aware of the rising concern about the mismatch between specialties that doctors wish to go into and those where patient need is greatest. There are important questions about the appropriate balance between specialists and generalists, and whether we have enough doctors in the right specialties to cope with an ageing population. The independent review of the Shape of Training will consider these issues.

### **An increase in complaints about doctors**

We continue to see a year-on-year increase in the number of complaints about doctors.

This increase is not necessarily evidence that standards are declining. In some cases, complaints may have risen because of improved clinical governance systems that enable improved reporting of concerns. In other cases, complaints may be unsubstantiated or not raise a question about a doctor's fitness to practise. However, the increase in complaints does mean that the likelihood of us investigating a doctor has increased from one in 68 in 2010 to one in 64 in 2011.

Although this increase reflects a rise in complaints across the NHS more broadly, and across other nations, it is striking that doctors were more likely to be complained about than other health professionals in 2011.

More importantly, more patients are willing to complain to a national regulator because they are dissatisfied with the care they or their relatives have received from their doctor. As a result, complaints to regulators in the UK are increasing. In 2011, complaints from the public accounted for 65% of all complaints we received. This is a significant issue for employers and the profession, as the constant rise does suggest, at least at one level, concern about the relationship between doctors and patients.

Looking at the types of complaints that we investigated, the number of cases about how doctors interact with their patients has increased, including those about doctors' respect for patients and how they communicate with patients. Although there is no evidence that these complaints reflect an actual deterioration in doctors' ability to communicate, they do reflect a change in the doctor-patient relationship. Providing patients with full information and listening to what they want are crucial elements of good medical practice.

Men, older doctors, GPs, psychiatrists and surgeons are overrepresented in complaints. Understanding this pattern is very important for the regulator, for employers and the profession more widely, so they can better support and target advice to help doctors meet the standards for good medical practice.

In the next chapter, we seek to understand what drives these overrepresentations by looking in more depth at the differences in the types of complaint that the GMC received, and how these differed for doctors at different stages of their careers.

## Chapter 1: A note on data

Data in this chapter are primarily drawn from the information we collect as a result of the GMC's work in registering doctors, quality assuring medical education and training, and assessing doctors' fitness to practise. Further detail of the data from each of these areas is included below. To provide context and further richness to the report, we have also included various pieces of external evidence. These secondary data include patient experience surveys and data from NHS written complaints, as well as complaints data from international and European regulators, and other UK health professional regulators.

### Registration data

Registration data are drawn from three main sources.

- The *List of Registered Medical Practitioners* (the medical register). This is the list of all doctors registered in the UK and includes provisionally registered doctors.
- The Specialist Register, established in 1997, which records the specialty in which a doctor either completed their Certificate of Completion of Training (CCT) or demonstrated that their training and experience allowed them to practise in a particular specialism.
- The GP Register, established in 2006, which includes the names of all those doctors who are eligible to be included on the register, and to work as GPs in the NHS, providing they also gain access to a performers' list.

Data were drawn from the GMC's database on 10 August 2012 and refer to the registers as at 31 December 2011. Our ongoing quality assurance processes mean that retrospective updates may have been made to the registers since publication of this report.

Data recorded on the three registers have some limitations. The address held for each doctor is their registered address for communication purposes, and is not necessarily aligned with their place of work. The specialty recorded for a doctor is the specialty they qualified in and may not reflect their current area of practice. In addition, some information fields, such as ethnicity and disability, are incomplete because doctors are not required to provide this information.

As we prepare for the implementation of revalidation, we are starting to collect more reliable data relating to where doctors practise. These data will improve with implementation from January 2013, and we are committed to increasing our understanding of where doctors are working.

### Education data

We have used the following data to provide a breakdown of the numbers of medical students, foundation doctors and specialty trainees in 2011.

- The total number of medical students was taken from the 2011 Medical School Annual Return (MSAR).
- The total number of foundation doctors was sourced from the 2011 Foundation Programme Office Annual Report.
- The figure for the total number of doctors in specialty training programmes was derived from Annual Review of Competence Progression (ARCP) data supplied by postgraduate deaneries. The data provided cover the ARCP period of August 2010 to August 2011.

### Fitness to practise data

We have used information held in our case management system about doctors at various stages of our fitness to practise procedures.

Fitness to practise information covers complaints received and cases closed between 1 January 2007 and 31 December 2011. There are key points in our process to which we have aligned the dates used to produce these statistics. These main points are:

- date when a complaint is received by the GMC
- date when a substantive decision is made at the end of our investigation process
- date that the adjudication process begins for cases referred to a hearing (ie the date that the hearing started).

Data were drawn from the GMC's database on 10 August 2012 and refer to fitness to practise complaints and allegation records as at 31 December 2011. Our ongoing quality assurance process means that retrospective updates may have been made to these records since the publication of this report.

# Chapter 2: Medical practice at different stages of doctors' careers

Doctors face different challenges at different stages of their careers and we need to develop a better understanding of those challenges to identify areas where they may need support. We also need a greater understanding of the types of health problem that can affect doctors' practice and how these change through their working lives.

To support the analysis in this part of the report, we have used time since qualification to approximate stage of career.\* Doctors who qualified between one and ten years ago are likely to be in postgraduate training or recently qualified GPs; those who qualified between 11 and 20 years ago are likely to have finished their specialist training. Those who qualified 21 years or more ago are likely to be working in more senior roles.

We have also considered whether where a doctor qualified has lasting effects on their practice, ie whether place of primary medical qualification is related to fitness to practise, and whether doctors' routes to specialist or GP registration affects their fitness to practise.

## Summary of chapter

This chapter looks at how the types of allegation that we investigated about doctors vary over their careers. It examines whether there are particular pressure points when doctors may need more tailored support.

### Key findings

- Newly qualified doctors were proportionally more likely to be investigated about probity than anything else.
- Where in the world doctors qualified did not affect the overall likelihood of them being complained about, but did affect the type of complaint. Older international medical graduate (IMG) doctors were more likely to be complained about than doctors in the same age group who qualified in the UK or EEA.
- Allegations investigated about clinical care and relationships with patients increased between ten and 20 years after doctors graduated from medical school, when they are likely to have finished specialty training.
- How doctors gained specialist or GP registration did not influence the likelihood of them being complained about. But the specialty they worked in affected both the volume and the type of complaints they faced.
- Only a very small number of the allegations that we investigated were about doctors' health. However, the majority of these related to substance misuse and mental health. The type of health issues varied at different stages of doctors' careers.

\* Using time since qualification and information on the average length of training, we have approximated the stage of career at which a doctor is likely to be. That said, these timings are indicative and so can vary. For example, extensions to training, less than full-time training and periods of absence will all extend the length of training.

## Section 1: Patterns in allegations at different stages of doctors' careers

### There are clear trends in the types of allegation investigated over doctors' careers

In spite of the increased referrals to the GMC over recent years (see chapter 1), the number of doctors who are subject to a full investigation remains relatively small and of those an even smaller number are found to be impaired. It is important therefore to be careful in drawing wider conclusions from this cohort of doctors. Nevertheless, they do represent a significant group of doctors who have for one reason or another experienced difficulties with the practice of medicine, and as such may tell us something about when and why things go wrong.

With this caveat in mind, in 2011 there were three marked trends in the nature of allegations that doctors face at different points in a career (see figures 2.1 on page 53 and figure 2.2 on page 56).\*

As time since the doctor qualified increased, we needed to investigate:

- a lower proportion of allegations about probity
- a higher proportion of allegations about clinical care with an overall increase that appears to coincide with the end of training
- a higher proportion of allegations about relationships with patients.

These trends are set in the context that the GMC

received proportionally more complaints about older doctors overall.

A fourth trend was apparent before qualification. Medical school data on fitness to practise issues reveal strong differences between men and women – male students were more likely to have conduct issues than female students.

### Box 6: A note on analysis

Analysis in this chapter is based on snapshot data, showing which allegations were more likely to be made against certain groups of doctors at a fixed point in time.

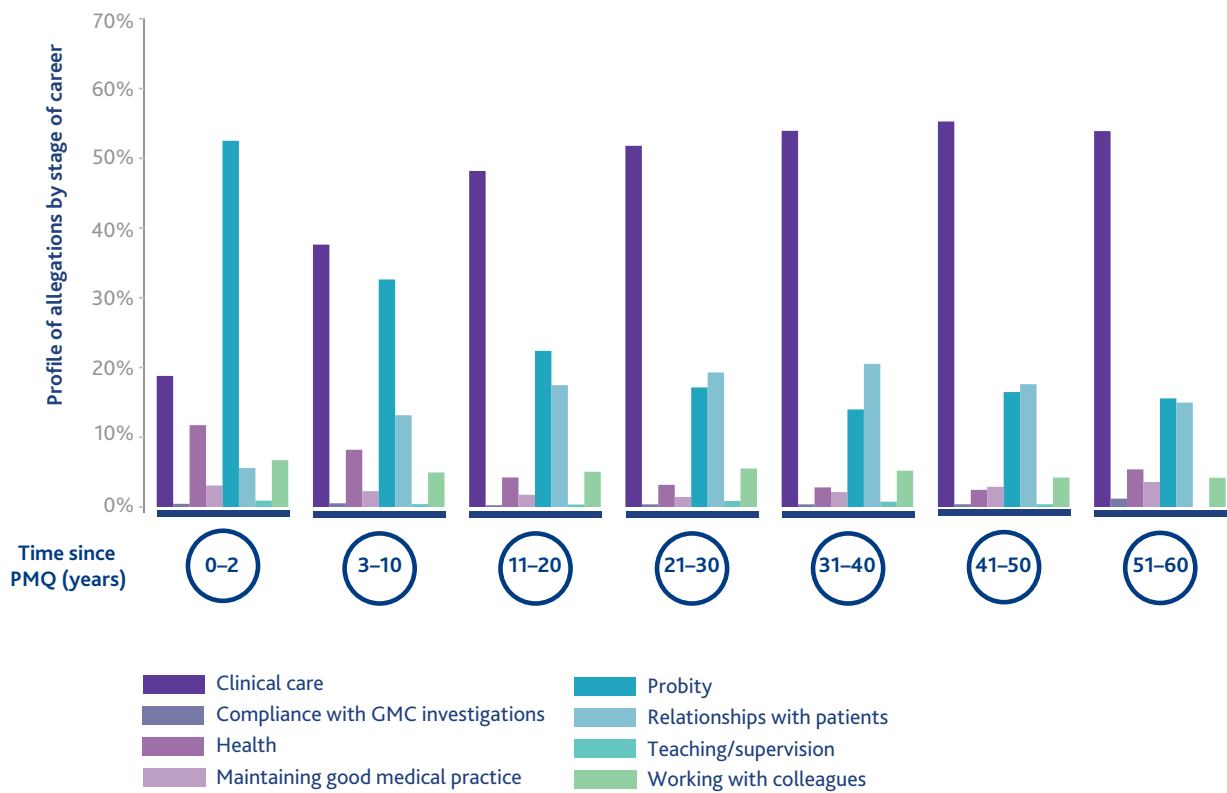
The analysis does not track a particular cohort of doctors over the course of their career. Neither does the analysis seek to conclude that we can predict the fitness to practise issues that doctors are likely to face in the future.

It is important to emphasise that the analysis compares proportions of allegations within each cohort of doctors. For example a larger proportion of investigations about younger doctors related to probity than to other issues, but the number overall was not larger than for other groups of doctors.

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\* See box 3 on page 40 for a description of the allegations categories shown in figure 2.1 on page 53.

Figure 2.1: Distribution of allegations investigated about doctors by time since primary medical qualification (2007–11)



### The rise in clinical care allegations over time may reflect doctors' increasing responsibility as their career develops

The increase in clinical care allegations around the time that doctors become consultants was also apparent in data collected by NCAS on its first eight years of referrals from 2001 to 2009. This showed that, in the hospital and community sector, consultants were most likely to be referred to NCAS,<sup>\*</sup> followed by non-consultant career grades, with a low referral rate for doctors in training.

There are two possible explanations. It may be that, from this point, doctors are less closely supervised and genuinely make more frequent, or more serious, clinical errors. But it may also be because, as the named individual leading the team, they are more likely to be held responsible if things go wrong. Or, it may be a combination of the two.

### Newly qualified GPs and consultants may need additional support

It has been suggested that today's newly qualified GPs and consultants have had fewer training opportunities, as a result of various changes in working patterns. For example, Working Time Regulations have reduced the number of hours in the working week. This means that today's doctors in training have access to less training time than their predecessors.<sup>139, 140, 141</sup> Chapter 3 looks at these issues in more detail.

There may be opportunities to provide newly qualified GPs and consultants with tailored support to assist them with this transition. One initiative of the Better Training Better Care<sup>†, 142</sup> programme in England, for example, involves mentoring and support for newly appointed consultants.

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\* Although NCAS was set up primarily to help with performance difficulties among career grade doctors, it has also accepted training grade referrals, but these are usually made by or in conjunction with postgraduate deaneries.

† Better Training Better Care has been established by Medical Education England to support delivery of the recommendations from *Time for Training* and *Foundation for Excellence*.

## Section 2: Stages of the medical career

### 2.1 Medical students and doctors in training

#### Male medical students are more likely to face complaints about their conduct, females about health

Each medical school has its own procedures to make sure students' behaviour is consistent with the professional standards expected of them as future doctors. The GMC provides guidance to medical schools on how to do this and the schools in turn report all cases they deal with to the GMC each year.

Only a very small proportion of undergraduates are subject to fitness to practise complaints – in 2011, there were 381 complaints in a medical student population of 41,268.\*

In 2011, complaints about female medical students were more likely to have arisen from their health than from their conduct. We look in more detail at mental and physical health among students, postgraduate doctors in training and more experienced doctors later in this chapter.

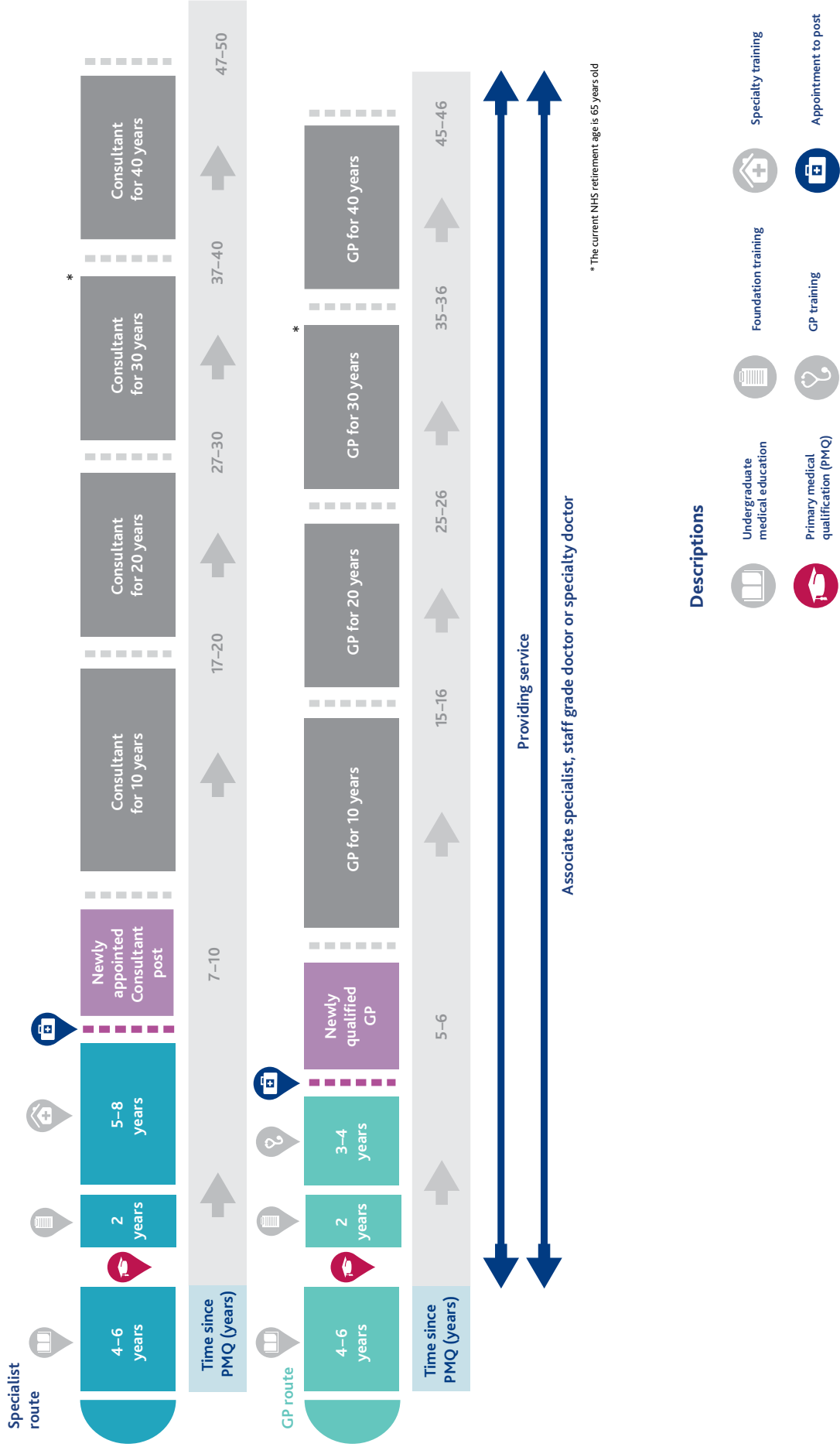
By contrast, male medical students were more likely to face complaints about their conduct.

These conduct issues can range from low level concerns such as lateness for lecture or clinical placements, through to more serious cases such as being under the influence of alcohol at a lecture or clinical placement, verbal abuse of a fellow student, plagiarism or cheating in exams. While some of these issues may appear relatively minor, if they begin to form a pattern of behaviour, they may raise questions about the professionalism of the individual and whether they will be able to meet the standards required of them as they enter the profession.

A study in the USA of more than 60,000 doctors over a ten-year period from 1990–2000 found that doctors disciplined by state boards were more likely to have demonstrated these kinds of unprofessional behaviour in medical school.<sup>143</sup> In some cases at least it seems possible that there may be a link between behaviour (and performance) at medical school and subsequent difficulties in practice.

\* These data are drawn from self reported information submitted by medical schools. The number of complaints refers to the number of complaints rather than students and more than one complaint may relate to the same student.

Figure 2.2: Medical career paths



These timings are indicative so can vary. For example, extensions to training, less than full-time training and periods of absence will all extend this.

### Newly qualified doctors are proportionally more likely to be investigated about probity than any other type of allegation

Overall, younger doctors received fewer complaints than older doctors. Of all complaints they did receive, a greater proportion of recently qualified doctors\* were investigated by the GMC because of probity issues than older doctors.† This was particularly pronounced in doctors in their first year out of medical school – probity accounted for more than 60% of the allegations about this group, compared with the average for all doctors of 20%. (See figure 2.3.) Allegations about probity included having a criminal conviction or caution, failing to notify the GMC of a charge or offence, and conduct. From 2007 to 2011, there were 590 allegations of a delay or failure to inform the GMC of an offence.

This higher concentration of probity issues may also reflect a lower proportion of clinical care issues for this group of doctors, who are more likely to be closely supervised at this point in their careers. Nevertheless, it demonstrates the importance of medical schools ensuring that all their students graduate with a good understanding of the GMC's ethical guidance, including the fact that they must declare any cautions or convictions, from anywhere in the world, at the point of registration. There is also a key role for the GMC to continue to ensure that medical students understand the provisional registration process and what they need to declare.

### Professionalism needs to be central to medical education and training

There may also be some wider issues, including how effectively professionalism is taught.

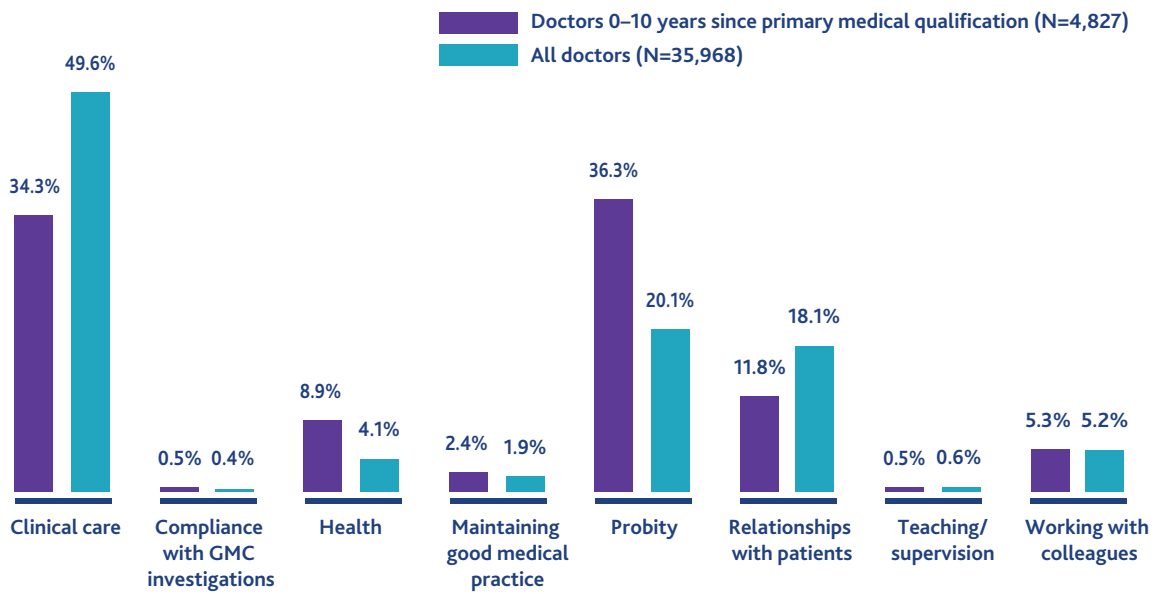
A systematic review of the development of medical professionalism published in the *International Journal of Medical Education* in 2010<sup>144</sup> found three main challenges in trying to teach medical students on this subject: there is a lack of consensus on the definition of professionalism, which presents a difficulty for curriculum design; there is no evidence base for the teaching and assessment of professionalism; and the concept of professionalism evolves as expectations of doctors change.

In a review of professionalism across different health professions, the HPC noted that 'the personal characteristics underlying professionalism may develop early in life as well as through education and work experience, but role modelling is also important in developing the necessary awareness of appropriate action in different contexts.'<sup>145</sup> In short, professionalism may not be easily taught in a classroom environment.

\* For this section, we have used datasets on 0–10 years since receiving their primary medical qualification as a proxy for doctors who are in postgraduate training. These timings are indicative and so can vary. For example, extensions to training, less than full-time training and periods of absence will all extend the length of training.

† We examined data over a five-year period to ensure that the numbers were sufficiently large to allow meaningful analysis and comparison.

**Figure 2.3: Distribution of allegations investigated about doctors between 0–10 years since gaining their primary medical qualification (2007–11)**



Nevertheless, given the changing expectations of patients and the profession there is a case for renewing the debate initiated by the Royal College of Physicians in 2005 with its report *Doctors in Society*<sup>146</sup> and by the subsequent engagement by The King's Fund with medical students<sup>147</sup> on what is expected of young doctors at the start of their careers.

The case for engaging medical students in this discussion is strong. They have privileges and responsibilities that differ from those of other students and, as such, different standards of professional life are expected of them.<sup>148</sup> Further work is required, by the GMC and others, to understand the issues that can affect medical students' professionalism. We will also consider this alongside our plans for developing an induction programme for doctors new to practice in the UK.

## 2.2 Where a doctor qualified

More than a third of doctors on the UK register qualified overseas. These doctors will enter UK practice at different points in their careers.

Where any doctor completed their primary medical qualification will have lasting effects on the way that they practise medicine. It is not clear whether there are real differences affecting the quality of care provided by some doctors who qualified outside the UK, or whether there may be systemic bias of some kind against them. For example, research to test the objectivity of patient questionnaires about the quality of doctors' practice found that patients were likely to score doctors who qualified outside of Europe less favourably. The same study found that doctors who qualified outside of the UK were likely to be scored lower by their colleagues.<sup>149</sup>

In terms of complaints to the GMC, the picture is more complex. Looking at all doctors on the medical register, doctors who qualified outside the UK were no more likely to be the subject of a complaint to the GMC than UK qualified doctors. The proportion of complaints about doctors who qualified in the UK, the rest of Europe and the rest of the world was broadly consistent with the representation of each of those groups on the register. (See figure 2.4 on page 61.)

However, on looking at the data more closely, three distinct patterns emerge.

First, when taking age into account as well as region of primary medical qualification, for EEA and UK doctors there were similar (increasing) number of complaints per doctor for each age group. However, for IMG doctors there were less complaints per doctor for middle-age doctors and noticeably more complaints per doctor for older doctors. (See figure 2.5 on page 61.)

There is a variety of reasons why this group of doctors is subject to more complaints. For example, it could be that those doctors are more likely to continue to practise at an older age than their UK and EEA qualified counterparts (so there are simply more older doctors still practising in this category). Alternatively, they could be working in roles and positions that have not been as well supported – for example, through access to regular continuing professional development. Or it may reflect the standard of training and ability when this cohort of doctors joined the register some time ago.

Second, doctors who qualified outside the UK were proportionally more likely to be subject to a GMC investigation about issues such as poor clinical skills and knowledge, lack of knowledge of the law or codes, and an inadequate participation in medical education. They were also more likely to be investigated about these issues within the first two years of joining the UK register.

Third, a larger proportion of complaints about overseas qualified doctors were sent to a fitness to practise panel following investigation. Once at panel, doctors who qualified outside of the UK and EEA – IMGs – were more likely to be erased than UK qualified doctors, but they were also more likely to be found not impaired and to have their case closed with no further action.

### We need to understand more about these patterns of complaints

Independent research<sup>150</sup> using fitness to practise data for April 2006 to March 2008 does throw some light on the issue although there were limitations to the data. The researchers were not able to look at the seriousness of the allegation, only the type or category of allegation.

The study found that cases involving doctors who qualified outside the UK were at increased risk of serious outcomes compared to cases involving UK qualified doctors. The data on type of allegation and other characteristics of the doctor (such as age, gender and specialty) partly explained the greater risk of serious outcomes but did not entirely explain it. Due to the limitations of the data the study was unable to look at whether this group of doctors were more likely to attract more serious allegations.

Figure 2.4: Distribution of complaints received by the GMC in 2011 relative to region of primary medical qualification

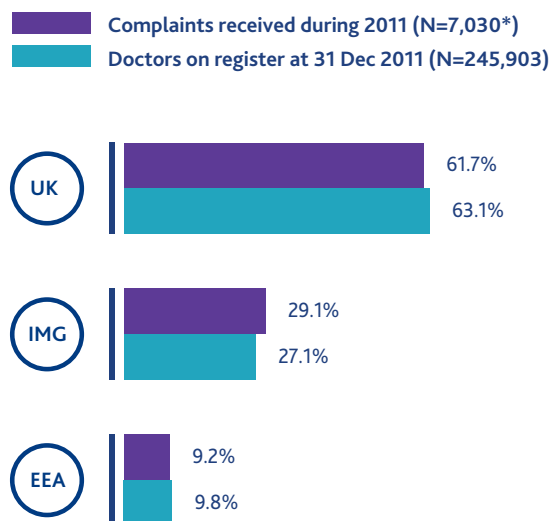
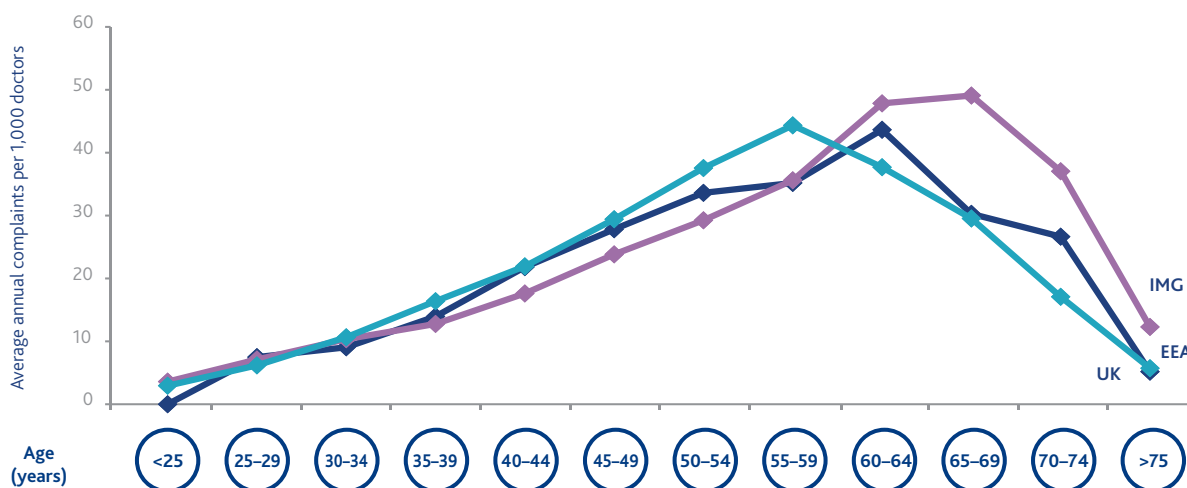


Figure 2.5: Average annual complaints per 1,000 doctors by age group and region of primary medical qualification 2007–11†



\* Not a complete data set of all complaints received by the GMC in 2011 as around 19% of complaints are in respect of doctors who are not identified.

† We do not currently have age information for around 3.5% of the register (approximately 8,200 doctors). In order to get as accurate a picture as possible from the data for this piece of analysis, we used time since first qualification as a proxy for age.

It is important to emphasise here that the study showed that increased risk for this group of doctors is not about their ethnicity but about the fact that they qualified outside the UK.

The study was not able to determine the reason for this but it is worth noting that the study also found that cases involving male doctors were at greater risk of serious outcomes compared to cases about female doctors and that this was also partly but not fully explained by the available data.

We are committed to continuing to increase our understanding of these issues. We are about to commission research to carry out an independent analysis of our investigation decisions to check that our decisions are consistent and made in accordance with our published guidance. This will repeat a similar independent study we carried out in 2007.

We also plan to commission independent research to examine our decision making guidance and the way we frame our allegations to ensure that there are no unintended consequences for any groups from our approach to these issues.

In the meantime, for the first time this year we have conducted a survey of doctors who have been through our fitness to practise procedures to ask for feedback on their experiences. We are collecting equality and diversity data as part of that exercise to enable us to examine whether different groups of doctors experience our procedures differently.

Of course, age and place of qualification are only two characteristics. While we have examined these here in depth to help develop a discussion about

the pattern of complaints and what might be done to support doctors, other characteristics will also impact on the likelihood of a complaint being made. For example, a doctor's gender and the specialty in which they work can also have an effect. We need to understand more about how these interrelated factors might impact on doctors' practice, and what they can indicate about doctors' support needs.

It is also vital that we continue to scrutinise our processes to make sure they are free from discrimination. This will require further research and ongoing willingness to engage with all concerned with this area. All doctors need to feel that they will be treated fairly and patients need to be assured that their safety will always come first. At the same time, the existing data clearly highlight the particular importance of supporting doctors new to UK practice.

A new national GMC induction programme for doctors new to UK practice will be piloted later this year. The aim is to help doctors understand what is expected of them in the UK and it represents one contribution towards addressing some of the issues identified with this group of doctors. Ongoing continuing professional development will also play a vital role. Over time, the introduction of revalidation should also help, not least because it places a spotlight on the need for professional development and on employers' responsibility to support it.

### Obtaining a primary medical qualification outside the UK also appears to impact on training outcomes

There is some evidence that doctors in postgraduate training who gained their primary medical qualification overseas are proportionally more likely to experience challenges in progressing through training.

Doctors in postgraduate training are assessed annually on whether they have the competences to progress to the next stage of training – the ARCP.

Although the absolute numbers are small, overseas qualified doctors were significantly more likely to have an unsatisfactory outcome in 2010–11. There was no difference between outcomes for EEA and other overseas graduates (IMGs) – 19% of both had unsatisfactory outcomes (1,813 of EEA trainees and 10,601 of IMG trainees). By comparison, the percentage of UK qualified doctors with unsatisfactory outcomes was less than half this at 9% (28,382).

We do not know why this might be the case, although we might expect that, in general, UK qualified doctors will have been better prepared to undertake UK postgraduate training than non-UK colleagues because that preparedness is an explicit aim of UK undergraduate and Foundation training. We and others will continue to look at data on exam outcomes to try to understand this important issue further.

## 2.3 Doctors on the GP or Specialist Register

Doctors who have completed GMC-approved specialty or GP training programmes in the UK are awarded a CCT. This allows them to join the relevant Specialist or GP Register, and then to apply for a substantive, honorary or fixed-term consultant or GP position in the NHS.

Doctors can also gain entry to the Specialist or GP Register through an alternative route by demonstrating they have the knowledge, skills and experience equivalent to that required for a CCT. They are then awarded a Certificate of Eligibility for Specialist Registration (CESR) or a Certificate of Eligibility for GP Registration (CEGPR).

### How doctors qualify as specialists does not influence the type or volume of complaints made about them

Our research shows that employers have a strong preference for CCT holders as opposed to doctors from an equivalence route – over 75% of employers sampled stated a 'preference or strong preference' for CCT holders – and regard them as more capable because of the nature of their UK training and the quality assurance of this training.<sup>151</sup> The same study revealed a similar view among doctors in postgraduate training, with bias in favour of CCT holders, which was more pronounced the further doctors progressed through training. 5.6% of foundation doctors thought that CCT holders were more capable, compared with 32.1% of final year specialty trainees.

Earlier research by PMETB<sup>152</sup> also found that doctors awarded a CESR were more likely than CCT holders to take longer than six months to be awarded a substantive post, suggesting that these doctors may find it more difficult to progress.

Despite this perception, there is no evidence that doctors on the Specialist Register<sup>153</sup> who entered the register through an equivalence route were overrepresented in GMC fitness to practise procedures. (See figure 2.6 below.)

**Figure 2.6: Proportion of fitness to practise cases\* by route to specialist register†**

	CCT	CESR
Number of doctors on Specialist Register by route	27,415	1,422
Number of doctors with fitness to practise cases by route	704	39
Percentage of doctors with fitness to practise cases by route	2.5%	2.7%

\* This included fitness to practise data from September 2004 to November 2010. These data were collected from September 2004, the month that PMETB was established, which previously was responsible for quality assuring postgraduate medical education and training in the UK. PMETB merged with the GMC on 1 April 2010.

† These numbers were drawn from 2005–10. While the review of equivalence routes looked at routes of entry onto both the Specialist and GP Registers, the precise figures were only provided for the Specialist Register.

In June 2012, the GMC completed a consultation on a proposed new model for evaluating doctors seeking inclusion in the GP or Specialist Registers through the equivalence routes. The new model replaces the current emphasis on review of historical documentation with a more objective evaluation of knowledge and current practice and performance in the UK. This should help create a route to registration which is more robust, and perceived to be more robust, than the current system, and which will help enhance the credibility of doctors who progress through this route.

### **There are differences in allegations investigated between specialties**

In 2011, the GMC investigated a higher proportion of allegations about clinical care (compared with other allegation categories) for doctors in some specialties than others, as shown in figures 2.7 on page 66 and 2.8 on page 67. Clinical care accounted for more than 50% of the total allegations about GPs, for example, compared with just over 30% for doctors working in emergency medicine.

There were also differences between specialties in allegations about relationships with patients\* – notably, psychiatrists, obstetricians and gynaecologists, surgeons and GPs were more likely to be investigated about this issue. Pathology and radiology were underrepresented, which is unsurprising given the nature of their contact with patients.

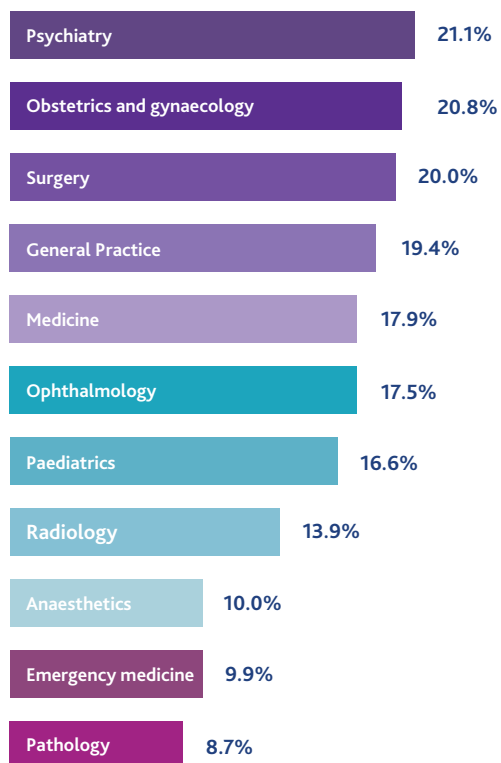
Similar findings were also seen in referrals to NCAS between 2001 and 2009 – psychiatry, general practice, and obstetrics and gynaecology had noticeably more referrals generally than might have been expected on the basis of their workforce size.<sup>154</sup>

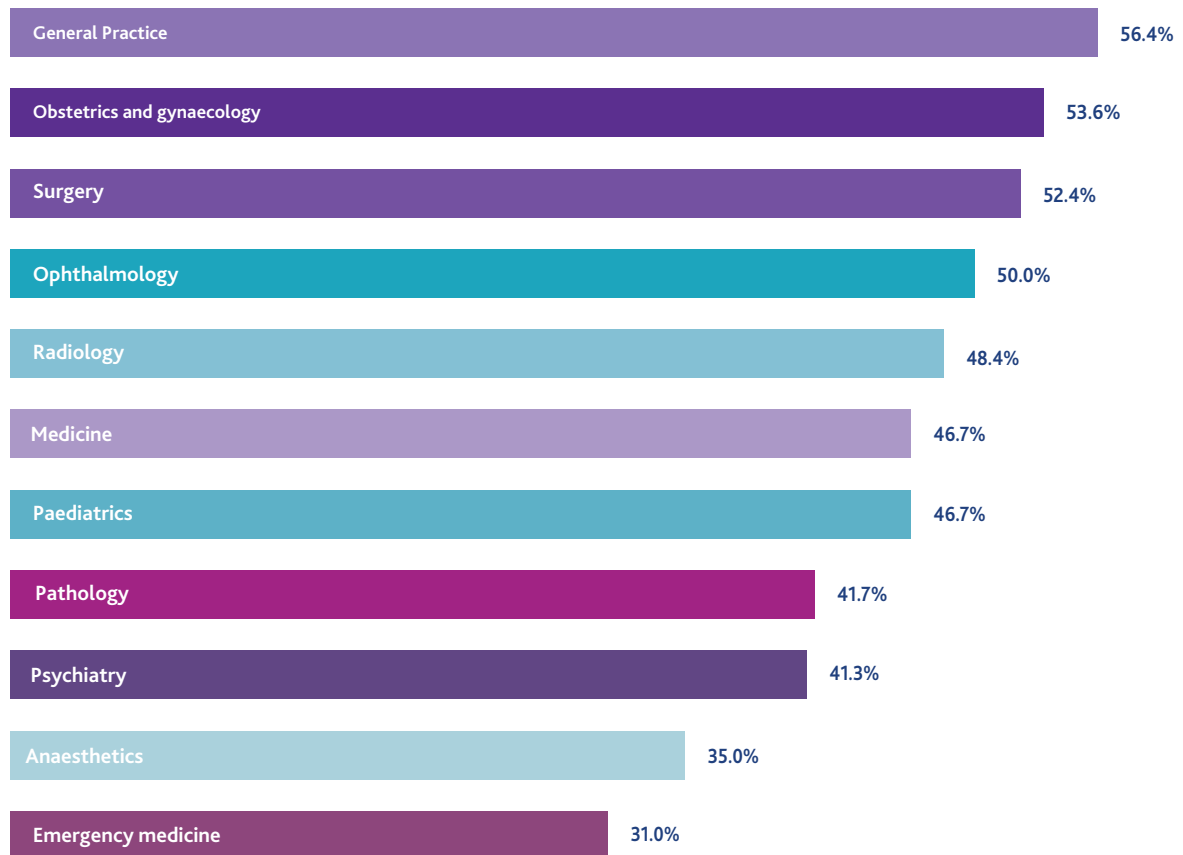
Understanding this pattern is helpful for the GMC, employers and for doctors themselves in ensuring good patient outcomes.

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\* As outlined in box 3 on page 40, these mainly include issues relating to how doctors interact and communicate with their patients.

Figure 2.7: Proportion of allegations about relationship with patients across specialties (2007–11)



**Figure 2.8: Proportion of allegations about clinical care across specialties (2007–11)**

## Section 3: Doctors in service posts

### 3.1 Locum doctors

#### Box 7: Who are locum doctors?

Locum doctors are doctors of any grade or specialty who provide cover when other medical staff are absent.<sup>155</sup> They can also include locum appointment for training (LAT) posts and locum appointment for service (LAS) posts.<sup>156</sup>

Locum doctors may be substantively employed by an NHS organisation but work additional shifts on a locum basis, or they may be employed by a locum agency that is contracted by NHS organisations.<sup>157</sup> Some doctors in training may also undertake occasional locum work. There are numerous types of locum doctors and many reasons why such doctors may be working as a locum. For example, they may be new to the UK and waiting to find a substantive post, they could be returning to work or training following a break from practice, or they may simply prefer that way of working. As such, locum doctors are not a homogeneous group, and their level of skills and experience and support needs will vary.

#### Information on locum doctors is limited

Locum doctors play a vital role in the UK's health systems (see box 7), but there is a lack of information about them. We do not know how many locums there are, where they qualified, at what stage they are in their careers or indeed where they are working.

With the introduction of revalidation, we will build a clearer picture of where all doctors, including locum doctors, are practising. The new system should also mean that, for the first time, all locum doctors are working in a governed or managed environment in which they have regular appraisals and their professional development is supported. As such revalidation should provide assurance over time that locum doctors, as other UK doctors, are competent and fit to practise.

#### There is a perception that locum doctors struggle to meet standards

A study published in the BMJ in 2011 found that locum doctors received lower scores of perceived professionalism than those doctors with a permanent employment contract.<sup>158</sup> This may reflect a more general view among doctors about their locum colleagues.

It is also clear that the governance of locum appointments is not as it should be. There is some evidence that not all employers undertake the necessary pre-employment checks or make sure that locum doctors have the necessary skills and competences.<sup>159</sup>

We hope that revalidation, while placing new and clear responsibilities on agencies for the quality of the doctors they are deploying, will also help to reinforce employers' responsibilities. NHS Employers in England has made it clear that all health service employers who use locum doctors must be compliant with the standards for appointment and employment of locum doctors that are set out in new guidance published in June 2012.<sup>160</sup> These include carrying out all necessary pre-employment checks, ensuring locum doctors have the required competencies and communication skills, offering effective induction and supervision, and ensuring that the appropriate doctor (usually the supervising doctor) provides appropriate feedback at the end of a locum doctor's placement.<sup>161</sup>

Where employers, or any health professionals working within those organisations, are concerned about a locum doctor's practice, they have a duty to report it. Sharing information between NHS organisations and locum agencies needs to improve<sup>162</sup> so that any poor practice is identified and addressed early.

Given significant shortages of doctors in some specialties, there may be pressure on those

responsible for local services to take on individuals who are nominally qualified to undertake the work. In the past relying on the recommendation of a locum agency and the fact that the doctor is on the GMC register has often been seen as sufficient. In future both locum agencies and employers, via their responsible officers, will have to be sure that any doctor they take on is both fit for practise and, in terms of the job that they are being asked to perform, fit for purpose as well. If this operates effectively, it will not only help to safeguard patients, it should over time improve perceptions of locum practice in the UK.

## 3.2 Specialty doctors

Specialty doctors\* tend to be experienced doctors who are not in a formal training programme leading to a CCT or working as a consultant. Their posts usually require them to be focused on the delivery of day-to-day care to patients.

In the past 20 years, there has been substantial expansion in this grade of doctor. In 1991, there were 490 staff grade doctors in England, whereas in 2009 there were around 12,800 specialty doctors and other non-training grade posts in England.<sup>163</sup> Figures are not available for Scotland, Wales and Northern Ireland.

\* In April 2008, the staff, associate specialist and specialty grades were amalgamated into one grade: the specialty doctor.

### Information about specialty doctors is limited

As with locum doctors, there is a lack of information and data about specialty doctors' standards of practice. However, there is some evidence that they have less access to support than other doctors do and are less likely to have their practice formally assessed. In England in 2011–12, 54% of specialty doctors had an appraisal, compared with 74% of consultants and 90% of GPs.<sup>164</sup>

The good news is that there are signs of improvement as organisations prepare for the introduction of revalidation. Appraisal rates for specialty grade doctors in 2010–11 were just 36%.<sup>165</sup>

At the same time, there are other moves to increase support for specialty doctors. For example, the Department of Health in England has produced a good practice guide, which calls for specialty doctors to have a minimum of one programmed activity per week to support professional activity, and effective appraisals.<sup>166</sup> Earlier this year, the Scottish Government awarded £1.4 million of funding for specialty doctors.<sup>167</sup>

As with locum doctors, the introduction of revalidation provides an opportunity not only to gather more information about specialty doctors and their needs, but also to make sure there is adequate clinical governance to support them. Employers and responsible officers will have to provide them with appraisals, and give them access to supporting information about their practice and multi-source feedback. Revalidation should also improve the information we collect on both specialty and locum doctors. This will give us a clearer view of the characteristics of these doctors, their particular support needs, and how we and others can help to address these.

## Section 4: Health concerns

### 4.1 Health concerns and fitness to practise

At any stage in their career, doctors may face ill health. In most cases, this will not affect their fitness to practise and they will never come into contact with either the GMC or any other organisation because of their condition. However, for a minority, health may affect their ability to practise and this needs to be reported to the GMC.\* (See figure 2.9 on page 72.)

The NHS Practitioner Health Programme (PHP) assesses and supports doctors who have problems affecting their work. Data on its referrals may give an indication of the proportion of doctors with a health issue who are referred to the GMC. These doctors may not necessarily also access support from the PHP, particularly as the majority of doctors accessing the programme are in the Greater London area, and some doctors' health concerns will be managed locally or not disclosed. From 2008 to 2011, 29% of dentists and doctors referred into the programme were also involved in GMC and GDC processes.<sup>†, 168</sup>

In most cases where we believe there is an underlying health issue that may be affecting a doctor's practice, we ask two doctors, normally psychiatrists, to carry out a health assessment. Over the past five years we commissioned nearly 1,384 assessments – an average of 277 a year (see figure 2.10 on page 72).

As many of the doctors undergo more than one health assessment, the average number of doctors affected is lower than 277.

Trends in health assessment data may help identify underlying issues and ensure more targeted support can be provided in the workplace before the doctor's ability to practise is adversely affected. As figure 2.10 on page 72 shows, the majority of health assessments undertaken related to alcohol issues. This could include offences relating to, for example, drink driving that do not relate to an underlying substance misuse issue.

#### Doctors may be more vulnerable to mental health problems than the general population

There is evidence to suggest that doctors have higher rates of mental health disorders than the general population.<sup>169</sup>

This is reflected in data on GMC health assessments from 2007–11: after alcohol and substance misuse, mental health issues, taken together, accounted for the largest proportion of all health assessments undertaken. By comparison, there were very few assessments relating to a physical health issue. A report on mental health and ill health in doctors, published by the Department of Health in England in 2008, cited occupational health statistics suggesting that doctors, along with armed forces personnel, have the highest incidence of work-related mental ill health.<sup>170</sup>

\* Doctors who were investigated about a fitness to practise concern about health issues may also have been investigated about one or several other concerns.

† 92% of all referrals to the programme were for doctors (compared with 5% for dentists and 3% for other healthcare practitioners).

Figure 2.9: Distribution of allegations investigated by the GMC (2007–11)

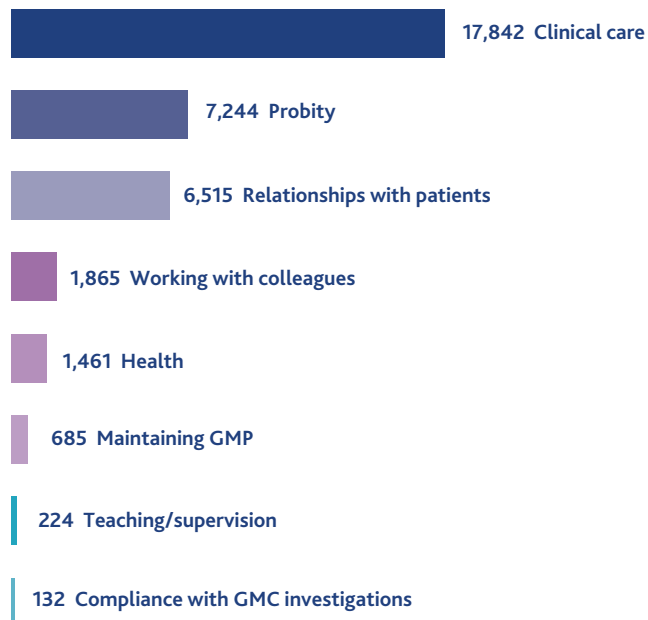
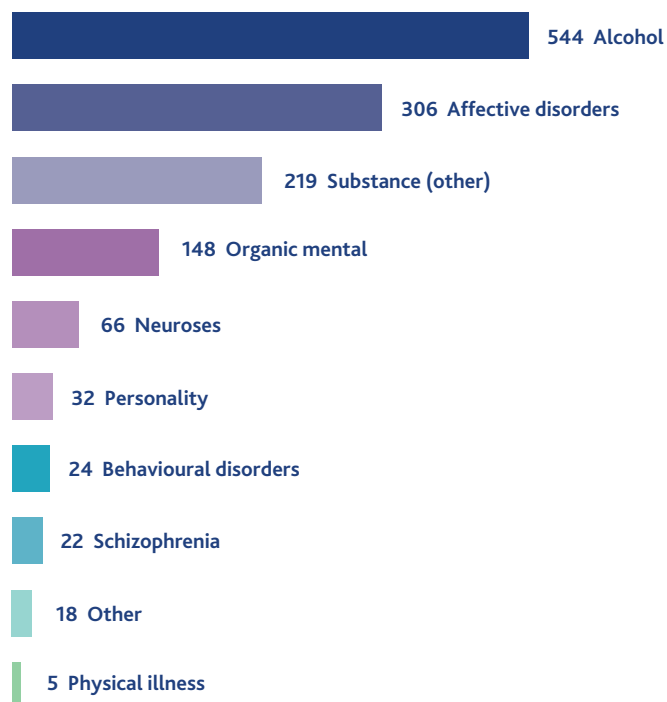


Figure 2.10: Distribution of health assessments performed by the GMC by alleged impairing condition (2007–11)



Contributory stress factors included work and service pressures, relationships with colleagues and the high demands and nature of the job itself.<sup>171</sup> The same report also noted increased suicide rates among doctors, which in part may relate to doctors' access to prescription drugs.<sup>172</sup>

Data on referrals to NCAS between 2007 and 2009\* showed similar findings. There were 338 health concerns, accounting for 23% of all referrals to NCAS during this time. Of these health concerns:<sup>173</sup>

- 27% related to anxiety, stress or burnout
- 25% related to depression and hypermania
- 22% related to alcohol misuse
- 14% related to substance misuse.

Referrals for doctors to the PHP between 2008 and 2011 were also predominantly in relation to mental health and addiction issues, accounting for 85% and 28% of referrals to the programme respectively. Referrals specifically for alcohol dependence made up 66% of all addiction diagnoses.<sup>174</sup> And the 2008 report by the Department of Health (England), noted above, stated that up to 7% of doctors will have a substance use problem during their lifetime.<sup>175</sup>

## 4.2 Health concerns at different stages of career

Just as there is evidence of different patterns of allegations across stages of doctors' careers, unsurprisingly there are also differences in the types of health issues that doctors are likely to face at different points in their careers.

There is a large evidence base about the prevalence of mental health issues experienced by medical students,<sup>176, 177, 178, 179, 180, 181, 182, 183</sup> which is reportedly higher than the general population and age-matched peers.<sup>184</sup>

Together with the Medical Schools Council, in June 2012, we commissioned research from Cardiff University† to look at how medical schools support students with mental health concerns. The report will also identify examples of good practice that will be shared between medical schools.

GMC health assessment data show that the problems faced by doctors younger than 30 years were more likely to be linked to alcohol than those in other age groups. Complaints about doctors in this cohort were also more likely to involve health issues overall relative to other issues.

This pattern is also reflected by the finding from the PHP that young doctors are particularly vulnerable to alcohol dependence and depression.<sup>185</sup>

\* In 2007, NCAS started to code reasons for referrals.

† In collaboration with Peninsula College of Medicine and Dentistry and Prepare to Share.

GMC data suggest a similar pattern relating to substance abuse, with a higher proportion of doctors aged 31–40 years being assessed for this reason.

Doctors aged 31–40 years received 45% of substance related assessments, compared with their average for all assessments of 32%. They were particularly overrepresented in cases involving cannabis, cocaine and stimulants such as amphetamine. Most cases were linked to convictions for possessing controlled substances, or to police or trust investigations into the misappropriation of drugs from NHS sources, usually involving opiates, benzodiazepines and other sedatives. Some cases relate to self-prescribing.

For doctors aged 41–60 years, the health issues affecting their fitness to practise were proportionally more likely to be linked to depression and neuroses than to substance misuse or alcohol. Affective disorders, which include different types of depression, affected proportionally more doctors aged 41–60 years, while neuroses particularly affected those aged 51–60 years.

Dementia and other organic mental disorders affected more older doctors, with a large overrepresentation in those older than 70 years.

### Supporting doctors with health issues

Anyone can suffer from ill health and, where this is a possibility, it is vital that doctors are supported in maintaining good medical practice so their patients are not affected and their health does not deteriorate further.

Although many employers provide support, many doctors are reluctant to seek it because of the nature of these conditions and the stigma that is attached to them. They may also be concerned that admitting the problem may affect their registration.

There are a number of independent organisations that specialise in helping doctors with mental health and addiction problems, including those run by the British Medical Association (BMA), the independent British Doctors' and Dentists' Group for drug and alcohol users, and the Doctors' Support Network, as well as general mental health charities such as Mind, the Mental Health Alliance, and substance misuse groups.

We are keen to encourage doctors to be open about health problems and seek support before problems worsen, but recognise that the regulator can be seen as intimidating and a threat to livelihood. For that reason, we want to minimise as far as we can the additional stress doctors experience when their fitness to practise is investigated.

We know that there is more we can do.

Earlier this year, we also launched a new website explaining how we deal with health cases, including who will be involved and what will happen. It includes case studies and sources of further advice and support.

We have also commissioned the BMA's Doctors for Doctors service to provide free, independent and confidential support to any doctor involved in our procedures. We are running this as a pilot until May 2013.

Next year, we will be commissioning research into how the GMC deals with cases involving doctors with health concerns. This will help us ensure that our processes, while protecting patients, also deal fairly and sensitively with doctors who are vulnerable.

## Conclusion

There is a clear change in the pattern of complaints over the course of doctors' careers.

This is not surprising. As with all professions, both preparatory education and training and career pathways change over time. Doctors will therefore have different experiences; both individuals and cohorts may find parts of their career more challenging. They may also face personal or health related difficulties along the way that affect their performance.

But these trends are important because they may make it possible for employers, the profession and the GMC to identify better ways to support doctors at different points in their careers. This will be important both for their own welfare and for that of their patients.

The most striking trend we have identified is around allegations in two categories – clinical care and relationships with patients. The allegations we investigated in these areas both increased around the time that specialty training ends and continued to rise thereafter. This highlights the critical importance of continuing professional development, and the need to ensure that all doctors, including locum and specialty doctors, have regular access to training and development.

Revalidation will help. It will mean that we and others have better data on doctors' support needs, because all doctors will need to submit a range of evidence as part of their appraisal process, and to demonstrate their ongoing fitness to practise. This will be a particular help in supporting locum and specialty doctors, about whom there is still a concerning lack of data.

Of course, caution is needed in interpreting these findings. The number of complaints we receive about doctors, although rising, is relatively small as a proportion of all doctors registered in the UK. And, while there are discernible patterns in the types of complaint we receive at different stages of doctors' careers, these are likely to be exacerbated by differences between the environments in which doctors work and train. In chapter 3, we consider in more detail how environmental factors can act as both barriers and enablers to good medical practice and, in chapter 4, how they can be overcome.

## Chapter 2: A note on data

This chapter draws on data collected as part of the GMC's fitness to practise processes, through our role in quality assuring medical education and training and through revalidation. Further details on the separate pieces of analysis used in this chapter are provided below.

### Differences in patterns of complaints at different points in doctors' careers

This analysis includes fitness to practise complaints reported to the GMC between 1 January 2007 and 31 December 2011, or cases that were closed between 1 January 2007 and 31 December 2011.

We have assumed that time since primary medical qualification is a reasonable proxy for a doctor's stage of training/career. There will be some exceptions to this, for example, doctors who may have taken longer to complete GP or specialty training, doctors who undertake less than full-time training or doctors who choose to take a break from training.

We compared data using characteristics of doctors such as doctors' age group (selected age groups) and time since primary medical qualification.

We have looked at these characteristics in isolation, and have not adjusted to account for potential influences of other variables, therefore these results present broader observations and do not necessarily imply causality.

### Analysis of health assessments

This analysis draws on data from health assessments completed by the GMC between 2007 and 2011. When the GMC receives information that suggests a doctor's health may be putting patient safety at risk, the doctor may be required to undergo a health assessment. A health assessment is one part of a wider investigation into the doctor's fitness to practise, and helps the GMC to understand any health concerns before considering what, if any, measures will be needed to protect patients.

# Chapter 3: Doctors in the workplace

The quality of medical practice is not only determined by the characteristics of individual practitioners, but can be shaped and influenced by the contexts in which they work and train.

This chapter examines the impact of the wider healthcare system and other external factors on medical training and practice.

## Summary of chapter

This chapter looks at where doctors work and train to understand how contextual factors impact on medical training and practice. In so doing, it seeks to understand better the issues and factors that might enhance or constrain good medical practice.

### Key findings

- There is little difference in complaints across the four UK countries and health systems, but some differences between regions of England in the type of allegations the GMC investigated between 2007 and 2011 – South Central (Berkshire, Buckinghamshire, Hampshire and Oxfordshire) had the highest proportion of clinical care allegations, and London had the highest proportion of relationships with patients allegations.
- There is evidence to suggest that the size of the organisation in which doctors work can impact on patient outcomes and patterns of complaints. Using the GMC's data, we found that NHS hospital trusts in England with fewer doctors had a higher proportion of complaints per doctors than those hospital trusts with more doctors.
- Workforce issues are continuing to impact on medical training and practice. There is a growing body of evidence that patient outcomes are worse on evenings and weekends, times when there is less senior doctor cover. And, in some specialties, recruitment difficulties are affecting both service provision and training, particularly in ensuring that doctors in training have access to adequate supervision and protected time for education.
- Organisations where doctors in training reported below average satisfaction with clinical supervision also had a higher proportion of complaints to the GMC.
- More can be done to support doctors to raise concerns if they feel patient safety is being put at risk. Employers must ensure doctors are appropriately supported to speak out when they see evidence of poor care.

## Section 1: Where doctors work

### 1.1 There is little difference in complaints across the four UK countries and health systems

A recent report from the National Audit Office highlighted the variation across health systems in England, Northern Ireland, Wales and Scotland. There were differences against a range of indicators from health outcomes and spending levels, to efficiency and productivity and the quality of services provided.<sup>186</sup>

Although influenced by much more than the healthcare system, life expectancy at birth was lower in Scotland than in England: 75.9 versus 78.6 years for men and 80.4 versus 82.6 years for women.<sup>187</sup> Clearly, caution is needed when comparing data from across four systems, because, in many cases, they have differing operational procedures and targets, and indeed methods for data reporting. Some measures may also provide data on the quantity rather than the quality of services.<sup>188</sup>

Nevertheless, the report also noted differences in NHS activity levels and waiting times. For example, GPs in Wales estimated seeing more patients per week than their counterparts in England, Northern Ireland and Scotland did, and activity levels per medical staff member in hospitals were highest in England and lowest in Scotland in 2008–09.<sup>189</sup> Likewise, the figures suggest different waiting times for six common procedures across the four countries, with lower waiting times in England and Scotland than in Northern Ireland and Wales.<sup>190</sup>

However, in terms of complaints to the GMC there appears to be a relatively consistent picture across the UK. The overall volumes of complaints in the five years from 2007 to 2011 were generally aligned to the population size of each country of the UK, with slightly fewer complaints per doctor in Scotland and Northern Ireland. (See figure 3.1 on page 82.)

There was also little variation in terms of the types of complaint, with one exception – doctors in Scotland were more likely to be referred for allegations about their health. Doctors working in Scotland accounted for 8% of all allegations yet they accounted for 12% of all health-related allegations. This may in part simply reflect the poorer health of the overall population in Scotland, with its lower life expectancy at birth,<sup>191</sup> and higher rates of some lifestyle diseases including, for example, alcoholism.<sup>192</sup>

### 1.2 Types of allegation investigated differ at a regional level

There were some differences between regions of England in the type of allegations we investigated between 2007 and 2011. Notably:\*

- South Central (Berkshire, Buckinghamshire, Hampshire and Oxfordshire) had the highest proportion of clinical care allegations, with 58.3%. Yorkshire and the Humber had the lowest proportion, with 49.1%. The UK average was 53.0%.

\* Regions were defined by former strategic health authority boundaries.

- London had the highest proportion of allegations about relationships with patients (24.0%) and south central England had the smallest proportion of allegations about relationships with patients, with 14.8%. The UK average was 19.7%.

There was no evidence of any other variation in types of allegation across different regions of England.

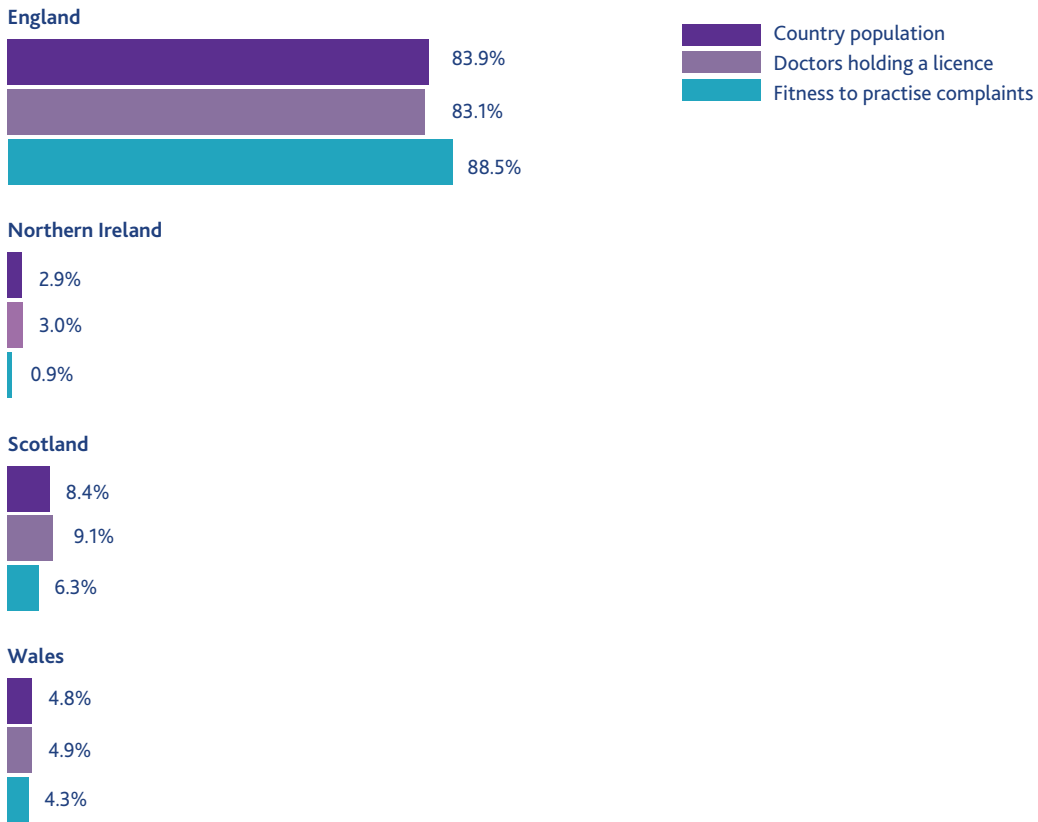
Differences of this kind do not necessarily point to better or poorer standards of practice. They may be influenced by a wide range of factors, including the quality of clinical governance, the balance between primary and secondary care, demographics and whether it is a more rural or urban area. For example, more complaints may reflect better clinical governance or differences in patient expectations rather than poorer patient care.

Nevertheless, that is not to say these findings are unimportant – they may indeed reveal real differences. There is some evidence, for example, that there are particular challenges around providing healthcare in London, which has a highly transient population and where migration even within the city is common.<sup>193, 194</sup> The turnover of clinicians is also high, with a greater use of agency staff.<sup>195</sup> These factors can limit continuity of care and affect levels of patient satisfaction. Again, given the high levels of patient turnover, it is not surprising that London has also been highlighted as an area with comparatively lower satisfaction with general practice.<sup>196</sup>

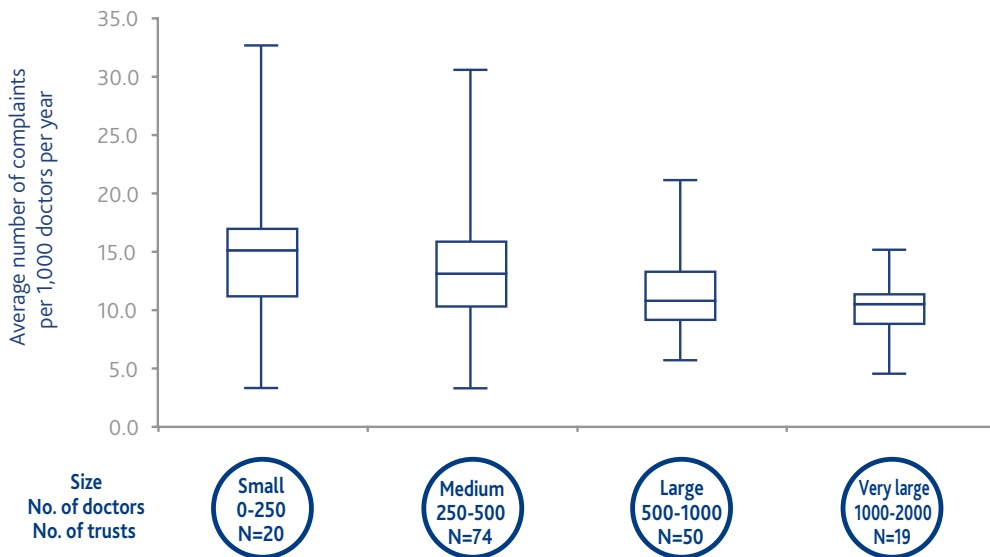
Through our regional liaison and employer liaison services, and our offices in each of the four UK countries, we have strengthened the links we have with partners across different regions, including local employers, patients and the public, and the medical profession, including medical students and doctors in training. These services will help us more quickly understand any regional concerns or issues. The employer liaison advisers in particular work with employers to help them understand what they need to do if they have concerns about a doctor.

Another avenue that is regularly explored is the difference in medical practice between rural and urban environments, which represent very different settings for how doctors work and train. The Commission on Generalism, for example, recently noted how 'generalism has a more extreme role to play in remote and sparsely populated communities [of the UK]', with some island communities in Scotland relying entirely on GPs to cover all medical presentations, including accident and emergency, pre-hospital and community hospital, and intermediate care. It also noted the significant challenges for these doctors accessing appropriate training.<sup>197</sup> A recent review on the configuration of hospital services in Wales made a similar observation, noting the staffing pressures facing hospital services in more remote parts of the country.<sup>198</sup>

**Figure 3.1:** Distribution of complaints received by the GMC across each of the four UK countries, relative to the UK as a whole, by population and the number of licensed doctors in each country



**Figure 3.2:** Average number of complaints per doctor by size of NHS hospital trust in England (2007–11)



The box plot above shows the range of values (complaints per doctor in trust) covered by the trusts in each size group. The top and bottom lines represent maximum and minimum values for each group. The box represents the range, which 50% of the values for the group lie within. The line across the middle of the box represents the median value for the group.

## Section 2: The organisations in which doctors work and train

There is a great deal of evidence demonstrating that the organisation where a doctor works can affect the way he or she practises medicine. Financial pressures, high levels of clinical demand relative to supply, the quality of managerial and clinical leadership and the relationship between doctors and managers can all have an impact on the care that is delivered.<sup>199, 200, 201, 202, 203</sup>

### 2.1 Organisational size

There is evidence to suggest that the size of the organisation in which doctors work can impact on patient outcomes and patterns of complaints.

A 2010 report on the relationship between management practices and healthcare outcomes, jointly produced by McKinsey and the London School of Economics, found a relationship between the size of a hospital, the effectiveness of its management practices, and the related impact on patient outcomes.<sup>204</sup> The study, which compared 1,100 hospitals across seven countries, rated larger hospitals as having better management practices,<sup>205</sup> and reported that hospitals with effective management practices had significantly lower mortality rates and improved financial performance.<sup>206</sup>

For the first time, we have begun to examine our data at organisational level. Again caution is needed in drawing firm conclusions at this stage, but the data do at least raise some interesting questions.

Analysis of GMC complaints data shows that, on average, smaller hospital trusts (those with fewer doctors) tended to have slightly higher numbers of complaints per doctor than larger trusts. While the difference in the number of complaints per doctors between smaller and larger trusts is relatively small, it is interesting to note the large variation in the number of complaints per doctor across trusts in the small and medium groups. (See figure 3.2 on page 82.)

Some caution is needed as more complaints per doctor in smaller hospitals could possibly simply reflect better clinical governance arrangements that pick up problems, or more transparency with patients and effective signposting to the GMC.

However, these findings could also reflect an aspect of the quality of medical care, the capability of the clinical governance arrangements in place, or a difficulty in getting in place the appropriate mix of medical skills.

We are starting to do more of this sort of analysis of fitness to practise activity by incident location. This will help us to identify trends at a regional and a trust or board level, and, with the introduction of revalidation, we should be able to gain a much clearer and more detailed picture of the state of medical practice. Building this evidence base, and sharing its findings with other healthcare regulators in the UK, will help us and others to drive up the quality of the systems within which doctors work.

## 2.2 Workforce issues and their impact on medical training and practice

As outlined in chapter 1, the number of doctors registered and licensed to practise in the UK has continued to grow in recent years, as has the number of doctors working in the NHS. Despite this growth, workforce pressures continue to affect certain specialties. The reasons for these pressures are complex and can vary from one organisation to the next, but are likely to include how services and staff are organised.

### Lack of cover by senior doctors appears to impact on patient outcomes

It is becoming increasingly clear that there are poorer patient outcomes at weekends and night and that this appears to be linked to fewer senior medical staff being on duty.<sup>207, 208, 209, 210, 211</sup>

Studies have demonstrated not only that patient experience can be affected over weekends and holidays, but that these times are associated with higher death rates. The outcomes of care are worse in a number of areas.

NHS London's *Case for change for emergency services in London* (September 2011) predicted that, if the weekend mortality rate was the same as the weekday rate, 500 lives could be saved each year. It concluded that this reduced mortality rate was directly related to reduced service at the weekend.<sup>212</sup>

The 2011 *Dr Foster Hospital Guide* took this finding one stage further and reported a link between higher mortality rates at the weekend and reduced

consultant presence.<sup>213</sup> Similar results were found in a review of emergency admissions in Wales, with patients admitted on a weekend, and especially on Sundays, more likely to die than those admitted between Monday and Friday.<sup>214</sup>

A large study involving an analysis of more than 14 million NHS admissions in 2009–10, in the *Journal of the Royal Society of Medicine* also showed an increased mortality rate of 11% and 16% for patients admitted on Saturdays and Sundays respectively, compared with patients admitted on a weekday. This was after adjusting for the differences in patient characteristics for patients admitted on different days.<sup>215</sup>

The evidence does suggest in particular that the absence of senior doctor support is a critical factor – in too many places hospitals are relying on doctors in training to provide care and treatment without adequate supervision. As the Academy of Medical Royal Colleges has recognised, there is an urgent need to map out the staffing requirements and service implications of implementing a consultant-delivered service throughout the seven-day week, at least in those specialties where evidence shows that outcomes are poorer at weekends and holidays.<sup>216</sup>

### Workforce pressures in certain specialties are affecting both service provision and training

Paediatrics, psychiatry and emergency medicine have all reported difficulties in recruitment.<sup>217</sup> This is reflected in the competition rates for training places in these specialties, which were considerably lower in 2011 than the more popular surgical specialties.<sup>218</sup>

The range of applications per vacant post was:

- 1.1 to 4.2 applications per vacant post in the first year of paediatrics\*,<sup>219</sup>
- 0.9 to 2.5 applications per vacant post in core psychiatry training<sup>220</sup>
- 0.8 to 1.0<sup>†</sup> in accident and emergency<sup>221</sup> applications per vacant post (which follows an acute care common stem training programme).

By comparison, in more popular specialties like trauma and orthopaedics (which follows core surgical training), the ratio was as high as 22.1 applications to each post available in some areas of the country.<sup>222</sup>

The NHS relies heavily on postgraduate doctors in training for much service provision.<sup>223, 224</sup> And, in some specialties, implementation of the Working Time Regulations has increased pressure on service rotas, meaning that doctors in training are often required to fill gaps in rotas.<sup>225</sup> As a result, problems in recruiting doctors to training posts can have a direct impact on the ability of certain specialties and organisations to meet service needs.

The impact of this was evident in a report published in June 2012 by the Welsh Institute for Health and Social Care, which found that, as a direct result of shortages in paediatrics, three Welsh health boards are now unable to staff paediatric rotas in a safe way, and in compliance with the 48-hour working week required by the Working Time Regulations.<sup>226</sup>

Pressures like these also have an impact on organisations' ability to provide safe and effective training.<sup>227</sup> In particular, since we became responsible for the regulation of postgraduate education, we have become concerned in the past few years about the lack of appropriate supervision for doctors in training in psychiatry and in emergency medicine, where there have been problems particularly at night, and around the supervision of doctors in the second year of foundation training.<sup>228</sup>

We support deaneries to act in individual cases, and if necessary act ourselves, where patients or doctors in training are at risk. But we recognise that these issues may at times be wider than the individual institutions about which concerns have been raised.

As the report on configuration of hospital services in Wales concludes, there may be merit in reducing the number of training sites for some specialties to ensure that there is safe and effective supervision in place for doctors in training at all times.<sup>229</sup>

No doctors in training should be put in a position where they are required to care for patients without adequate access to supervision and support. The GMC has audited the supervision of doctors in the second year of foundation training in all emergency departments in England to understand this issue in more detail, and we are working closely with deaneries and local education providers, who are required to take immediate action where we find evidence that doctors in training have not received adequate supervision.

\* This range covers the deanery area with the lowest application to vacancy ratio (1.1) to the deanery area with the highest (4.2).

† This is an average figure across all deanery areas.

Although we remain committed to allowing those on the ground to find local solutions, we will withdraw approval for training programmes if we are not satisfied that doctors in training are being adequately supervised. We have come close to doing this in the past, but have so far been able to find a solution with deaneries and others acting quickly to ensure improvements are implemented that address the problem.

### Time for training must be protected

An issue persistently raised with GMC staff, and in the annual specialty reports provided to the GMC by the medical royal colleges,<sup>230</sup> is the difficulty of managing the tension between service pressures and ensuring that doctors on postgraduate training programmes have access to dedicated time for education and training.

The 2011 national survey of doctors in training provided some evidence of the pressures, with almost 35% of trainees reporting that they had been asked to work beyond their rostered hours on a weekly basis, and a further 16% on a daily basis. (See figure 3.3 on page 89.)

Research by Durham University on the impact of the Working Time Regulations (commissioned by the GMC) has suggested that the tension between service pressures and time for training is likely to continue as financial pressures facing the NHS increase.<sup>231</sup>

It may also affect the time available to trainers. In their annual specialty reports to the GMC, the

Royal College of Psychiatry and the College of Emergency Medicine both expressed a concern about trainers' reduced time for supervision, with educational sessions being reduced in consultants' job plans because of increased service demands.

These concerns were also reflected in the responses we received to proposals for recognising and approving trainers\* early in 2012, which highlighted some concerns about senior doctors having enough time to train and supervise their younger colleagues.

It is important that time for training is protected for both doctors in training and their trainers, and that, in the case of the latter, enough time is reserved in their job plans.

Organisations that are responsible for training doctors need to consider what more they can do to build educational opportunities into day-to-day practice. In his review of the impact of the Working Time Regulations, Sir John Temple called on educators to 'make every moment count' for doctors in training.<sup>232</sup> A similar conclusion was reached by a GMC commissioned study into the effects of the Working Time Regulations on medical education, which suggested that there is still more to be done to embed medical education into medical practice in the workplace, and to change what many doctors in training perceive to be a separation of education and work. The researchers noted, however, that this requires senior medical presence on wards, in units and in theatres so that doctors in training can work alongside senior colleagues, learn from them and develop.<sup>233</sup>

\* From 6 January to 30 March 2012, we ran a consultation on the proposals for recognising and approving trainers. We currently approve GP trainers of GP registrars, and intend to move towards a more wide-ranging system whereby other trainers will be recognised by the medical schools and the postgraduate deans. In the longer term, we hope to acquire the legal power to introduce GMC approval of non-GP trainers.

### Redesigned services can free up time for training

There are some good examples of redesign initiatives that have freed up time for training. For example, new consultant resident working posts have been introduced in obstetrics and gynaecology. As a result, doctors in training have been released from some service provision, enabling them to focus on educational goals and to take part in training opportunities.<sup>234</sup>

The Better Training Better Care<sup>235</sup> initiative, led by Medical Education England, has begun to look at ways of addressing this by building on service redesign to draw on greater consultant involvement in the delivery of care, and to make sure that there is appropriate supervision in place for doctors in training.

#### Box 8: How did satisfaction with medical training in 2012 compare with 2011?<sup>236</sup>

Data from the national survey of doctors in training provide evidence of postgraduate trainees' perceptions of their experiences of medical training. However, its findings need to be considered in the context of other sources of information used to assess the quality of medical education and training, for example, responses to concerns and inspections of deaneries and local education providers.

In three areas, satisfaction scores showed small increases from 2011 to 2012.

##### Overall satisfaction

- In 2012, the overall satisfaction with training score was 80 out of a possible 100, up slightly from 79 in 2011. This increase was not significant, although it represents a continued trend of rising satisfaction.

##### Experience

- In 2012, 74% of trainees rated the practical experience they were receiving in their current post as excellent or good, up from 73% in 2011.

##### Handover

- In 2012, 23% of doctors in training reported that handover arrangements before night duty were informal or not in place. The quality of handover is important in ensuring continuity of care for patients. This is a slight improvement on 2011, when 27% of doctors in training reported that handover arrangements before night duty were informal or not in place.

In areas like feedback from senior staff, there was a less positive picture.

##### Feedback

- 33% of trainees in 2012 reported that they rarely or never had informal feedback from a senior clinician on how they were doing in their post, which is a greater proportion than in 2011 when 28% of trainees reported this.

## 2.3 The impact of organisational culture

Personal values, education and training, and well understood standards play an important role in medical education and training. This year has seen a focus on the extent to which doctors' alienation from their wider organisation can impact on patient care with sometimes tragic consequences. There is growing evidence both from this country<sup>237, 238</sup> and from overseas<sup>239</sup> of the relationship between organisational culture and the extent to which doctors, and other staff, feel engaged and connected to that organisation, and its overall performance. Organisations in which doctors feel more engaged with maintaining and enhancing the performance of the organisation perform better both financially and clinically.

### Organisations where doctors in training reported below average satisfaction with clinical supervision also had a higher proportion of complaints to the GMC

Drawing on the GMC's data, we found a relationship between reported satisfaction with clinical supervision within particular organisations and the volume of complaints to the GMC from those same organisations.

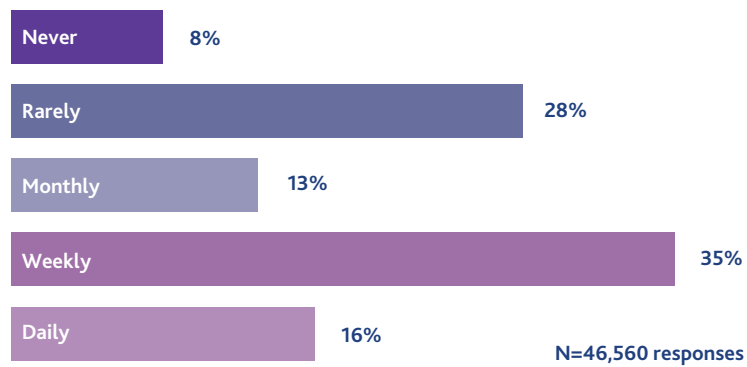
In hospitals where doctors in training reported below average satisfaction with their clinical supervision, there was a higher than average number of complaints made about doctors. (See figure 3.4 on page 89.)

Again, some care is needed in interpreting these findings. Higher referral rates could be the result of a range of factors, including improved clinical governance systems and reporting culture, so they do not necessarily mean poorer standards of practice.

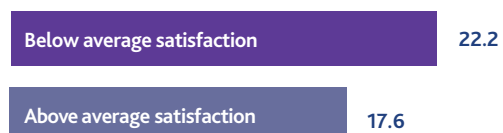
However, the findings are important because they may help our understanding of what factors are found in better performing hospitals, which will be of interest to a wide range of organisations and the public.

Evidence also suggests that organisations that value continuous learning and improvement perform better.<sup>240</sup> And, as noted in research by Durham University, successful implementation of the Working Time Regulations also requires effective leadership and a willingness to set priorities and invest in training opportunities, despite service pressures.<sup>241</sup>

**Figure 3.3:** Responses to 2011 national training survey question: 'In this post, how often have you worked beyond your rostered hours?'



**Figure 3.4:** Number of complaints per 1,000 doctors in an organisation compared with trainees' satisfaction with clinical supervision (2011 national training survey)



### Organisations in which doctors feel engaged perform better

Evidence suggests that organisations in which doctors feel engaged perform better,<sup>242</sup> and that higher performing hospitals have managers, particularly clinical managers, with higher levels of autonomy than lower performing hospitals do.<sup>243</sup>

With the NHS across the UK facing significant financial pressures,<sup>244, 245, 246, 247</sup> service reconfiguration,<sup>248, 249, 250</sup> and, in some parts of the UK, major structural reorganisation,<sup>251</sup> the need for clinical engagement has never been greater.

This relationship between the board, managers and clinicians seems to be crucial. The final report of the first Mid Staffordshire NHS Foundation Trust Inquiry described the sense of disconnect that some doctors felt between themselves and the organisation. It noted how 'the consultant body largely dissociated itself from management and often adopted a fatalistic approach to management issues and plans'.<sup>252</sup>

There has since been further evidence of what some believe is a growing sense of alienation among doctors and other frontline practitioners. A survey of healthcare leaders, administrators and clinicians highlighted pronounced differences in perceived priorities and values between clinical and managerial staff within the NHS. This applied throughout the organisation, with only 24% of medical directors surveyed feeling that managers were driven more by clinical rather than financial priorities. The same survey found that the negative perceptions of management increased closer to the frontline – doctors involved directly in patient care were the most negative.<sup>253</sup>

The sense in which doctors and managers see themselves occupying different worlds and belonging to different tribes is certainly not new, but it is clearly an impediment to effective working. This was recognised in the 2008 review of the NHS in England led by Lord Darzi, which promised to strengthen the involvement of clinicians in decision making at every level of the NHS. The review noted that change is most likely to be effective if it is led by clinicians. The latest reforms in England repeat this pledge to 'empower professionals'.<sup>254</sup>

However, in reality, involving, engaging and empowering doctors and other health professionals will require cultural and behavioural change on the part of leaders within organisations and doctors themselves. At a time when resources are tight and demand for healthcare is growing, this will be harder to achieve but more important than ever. It will require concerted action from all parties – as the national regulator for doctors, setting standards for education and practice, the GMC has a part to play. But it will also require the leadership of the entire profession, including the medical royal colleges and the BMA, as well as manager and employer organisations. This must be a priority, irrespective of the organisational framework within which we are all operating.

Earlier this year, we produced guidance on *Leadership and management for all doctors* and sent this to all registered doctors.<sup>255</sup> Good healthcare is about more than safe and effective medical interventions, and doctors have a crucial leadership role to play, in terms of both their own practice and that of their colleagues, and indeed the performance of the teams and organisations in which they work.

The guidance is obligatory for all doctors, but bringing about change in this area is largely about winning hearts and minds and creating new cultures at local level. The commitment of senior managers and doctors, as well as NHS boards, will be critical if this is to happen.

### Doctors must take responsibility for raising concerns

Closely allied to local leadership and culture is the question of the extent to which doctors and others feel able to raise concerns about patient care and the performance of systems and individuals. Again there is unambiguous evidence of staff not feeling able or empowered to raise concerns, even where they are concerned about patient safety.<sup>256, 257, 258</sup> There have also been notable examples over the past couple of years where staff have raised concerns but they have either not been listened to or found themselves in trouble or prevented from speaking out by so-called gagging clauses.

### Institutional and cultural factors can discourage doctors from raising concerns

There are barriers in some institutions to raising concerns. Sometimes the individual may feel that someone else is 'taking care of the problem', that 'nothing would happen as a result', or that they will face retribution of one kind or another.<sup>259</sup> One study, published in 2010, also suggested that there continues to be a 'deeply entrenched belief in medicine that only bad doctors make mistakes'.<sup>260</sup>

The key must be to create a culture in which staff feel confident that, if they raise concerns, they will be supported and will not experience negative consequences as a result. The GMC has a role here in making clear the obligation on all staff to raise concerns and to encourage organisations, and their medical leaders, to foster a more transparent and open culture in which raising and identifying concerns is seen positively as an opportunity for learning.

Of course, doctors who wilfully ignore patient safety issues are putting their registration at risk – raising concerns and highlighting issues affecting patient safety are not optional – but success in this area lies more in creating open cultures than in encouraging blame and retribution.

Although many of the complaints and concerns around the standards of care at Mid Staffordshire NHS Foundation Trust related to nursing care, some doctors working there failed to raise concerns about substandard care or to alert managers or outside authorities of what was happening at the trust.<sup>261</sup> This reluctance to raise concerns appears, at least in part, to have been linked to their lack of trust in managers at the organisation.<sup>262</sup> That is not an excuse for failing to act.

The 2011 NHS Staff Survey in England showed that too few medical and dental staff felt confident that their employer would address a concern if they raised it; with just over half (56%) reporting that they felt confident that concerns would be addressed, compared to 54% in 2010.<sup>263</sup> (See figure 3.5 on page 93.) In the 2010 NHS Scotland staff survey, only half of respondents believed it was safe to speak up and challenge the way things are done if they have concerns about quality, negligence or wrongdoing by staff in their NHS board. A quarter felt neutral and a quarter felt it would be difficult.<sup>264,\*</sup>

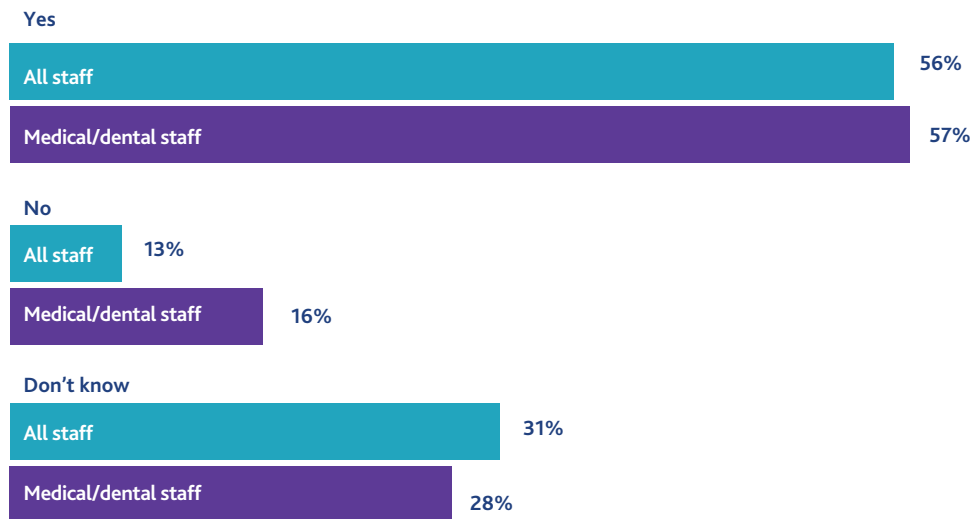
And data from our 2011 national training survey show that, while 82% thought reporting was encouraged and followed up, 15% said reporting was haphazard and not followed up. 3% said staff were reluctant to report due to a 'blame culture'. (See figure 3.6 on page 93.)

For the first time this year, the survey included a specific question on whether doctors in training had concerns over the safety of their patients. 2,337 doctors (5% of all respondents) raised a patient safety concern. Of these, 77% reported that they had been able to raise these concerns within their workplace or the local deanery that oversees their training; 23% said they had not.

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\* There were no comparable staff surveys carried out in Wales and Northern Ireland in 2010–11. The Scottish staff survey is carried out every two years.

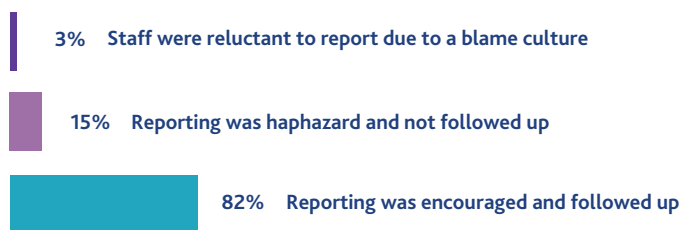
**Figure 3.5:** Responses to the 2011 England NHS staff survey question: 'If you raised a concern, would you feel confident your trust would address your concern?'



All staff: N=118,876 responses

Medical/dental staff: N=6,398 responses

**Figure 3.6:** Responses to the 2011 national training survey question: 'In this post, please indicate your perception of the way in which critical events and near misses were reported in your department'



N=46,560 responses

Doctors in training have a fundamental role to play in maintaining patient safety and raising concerns when they feel it is at risk.<sup>265</sup> Indeed, their perspective may bring a fresh pair of eyes to practices that have become ingrained. At the same time, we need to recognise the barriers they can face in raising concerns, particularly when they are likely to be in posts for relatively short periods of time.

The responses to the patient safety question show how much more needs to be done generally to drive up the safety and quality of care. The number of responses also shows that, although most doctors in training had felt able to raise their concerns, a large minority had not. Again, there is more that medical and health leaders can and should do to tackle this.

### Employers must support doctors to raise concerns

This year, for the first time, we issued specific guidance to every doctor in the UK on *Raising and acting on concerns about patient safety*.<sup>266</sup> It gives advice to doctors on the steps involved in raising concerns, and explains their responsibilities when colleagues or others raise concerns with them. It also makes clear that doctors should not enter into contracts or agreements that stop them from raising concerns, and that their employers should not seek to make doctors sign such agreements.

There does appear to be greater awareness of this issue – possibly because of the recent publicity it has attracted. For example, from 2010 to 2011, there was a 25% increase in calls to the Public Concern at Work helpline, and the majority of these were concerns being raised by staff in the care sector.<sup>267</sup>

But all the recent inquiries into failures of care<sup>268, 269, 270, 271</sup> demonstrate how much more still needs to be done. This is supported by a recent study in the USA on incident reporting, which showed that existing systems were only capturing 14% of incidents,<sup>272</sup> as well as a GMC-commissioned study on prescribing practices in primary care, which concluded that doctors should be more ready to report incidents and concerns beyond their own practice.<sup>273</sup>

At a national level, the GMC, the medical royal colleges, and the BMA need to set a tone that fosters this new culture. Perhaps even more importantly, local healthcare leaders – whether they are commissioning or providing services, or working in the public or private sector – must foster transparency, curiosity and a learning culture where mistakes are opportunities for learning. It also means being more open with the public about performance and providing feedback to clinicians.<sup>274</sup>

## Section 3: The patients who doctors treat

The population of patients who doctors treat, their background and how they present themselves for care can all affect how doctors practise medicine. Patients have different needs, expectations and attitudes to healthcare, and these have all changed markedly over recent years.<sup>275</sup>

Providing good medical practice means adapting to the needs and situation of each patient. However, it is not just a doctor's own attitude to their patients that is relevant, it is also the way in which doctors and other health professionals treat and care for different groups of patients – especially the most vulnerable.

Children, elderly people and people with disabilities have always been susceptible to receiving poor care, and they continue to be associated with the most worrying failings in care. The inverse care law,<sup>\*</sup> first described in 1971, whereby those with the greatest need receive the worst care, is still evident in many parts of our system today.

This is particularly pertinent as the proportion and number of patients aged 65 years and older continue to increase,<sup>276</sup> a fact to which the health services and health professionals alike seem to be struggling to adapt.<sup>277, 278</sup>

Older people already occupy most beds in hospitals, yet there is evidence of substandard care both in acute hospitals and in residential care.<sup>279, 280</sup> The Care Quality Commission's *State of Care* report for England in 2011<sup>281</sup> pointed to significant concerns about the suitability of some care home premises, and the BBC's *Panorama* programme on elderly care, broadcast on 23 April 2012, has exposed appalling mistreatment of residents with dementia.<sup>282</sup>

Less obvious, though no less important, has been evidence pointing to the lack of dignity afforded to older people in the health and care systems.<sup>283, 284, 285, 286, 287, 288</sup> At one level this is simple – every member of staff, and especially every professional, has an unambiguous duty to safeguard the patients in their care. The Commission on Dignity in Care for Older People, which reported in 2012, has made clear that every individual member of staff within a healthcare organisation is responsible for ensuring that older people are treated with dignity.<sup>289</sup> The Commission also highlighted the opportunity for revalidation to capture evidence about whether doctors are providing dignified care.<sup>290</sup>

\* In 1971, Julian Tudor Hart, a GP in South Wales, described the inverse care law: 'the availability of good medical care tends to vary inversely with the need for the population served'.

The protection of people with learning disabilities also remains an area where, in spite of numerous inquiries and changes in the way services are delivered, there is room for improvement.<sup>291</sup> A progress report by Mencap in 2012 highlighted that there has been insufficient progress in improving the care provided to people with learning disabilities, following the publication of *Death by Indifference* in 2007.<sup>292</sup> Drawing on case studies of deaths reported to Mencap between 2009 and 2011, the update report highlighted common and all too familiar themes across all of these cases: lack of basic care, poor communication, delays in diagnosis and treatment, and inappropriate use of do not resuscitate (DNR) orders.

This year, we launched a new website that gives doctors practical advice on the key issues to consider when treating a patient who has learning disabilities.

We have also published new guidance for all doctors on their responsibilities to protect children and young people, whether or not they routinely treat them as patients.<sup>293</sup>

Many doctors already collect and consider patient feedback as part of their professional development. As revalidation is introduced, all doctors will be required to do this, since patient feedback will be a key part of the information doctors need to reflect on as part of their annual appraisal. This will stimulate the use of formal patient feedback across the whole medical profession for the first time, recognising how important it is for doctors to take account of what their patients think of their professional skills. In time, patient feedback collected for the purposes of revalidation will provide invaluable insights not just into patients' experience, but also outcomes.

We and others need to understand more about what drives these variations in patient experience and outcomes. This includes identifying what doctors need from their working environment to make sure they can give their patients the highest standards of care, and to make sure they are able to raise concerns where that does not happen.

There may also be more to learn from the experience of patients at the centre of the complaints we receive. We need to look more closely for patterns and trends in complaints, so that we and others can learn from this and get a clearer view on what improvements may be needed.

## Conclusion

For everyone in work, the organisation, culture and resources available to them can support or hinder their performance. This is just as true for doctors. Understanding the factors that might enhance or act against good medical practice is an area that is underdeveloped.

The organisations that doctors work in are critical. Working practices, workforce issues and organisational culture all contribute to doctors' ability to provide good medical practice. There is a wealth of evidence that patients suffer when there is less cover from senior doctors, and this must be tackled. Organisations must find ways to respond to reduced working weeks and to other workforce challenges, and they must do so in ways that do not compromise the care patients receive or the quality of doctors' training.

For the first time, we have used our data on training satisfaction and data from fitness to practise together, and found an interesting relationship: organisations in which doctors in training reported below average satisfaction with training also had more complaints to the GMC. As we continue to develop the data we hold and the ways in which we are able to use it, we hope to understand better the environmental factors which contribute to good medical practice.

We should also understand more about the patients' perspective – who they are, what they are complaining about and what stops them complaining. There is evidence that certain groups of patients continue to have worse experiences of care and worse outcomes from that care. These are often the most vulnerable patients, and they may be the least likely to complain and the most likely to find it difficult to navigate through our and others' complaints systems.

A thread that connects many of these themes is that some doctors may feel disconnected, and even alienated, from their working environment. When this happens, they may be more reluctant to raise concerns, perhaps having less faith that these will be acted on. It is therefore vital that these doctors are reengaged. This may be challenging when services need to be organised to maximise patient outcomes, for example to include weekend working, in a way that fundamentally alters working patterns. This kind of reorganisation will be a major challenge for the medical profession as well as the rest of the healthcare system, and doctors need to take a lead in helping to bring this about.

It is these types of barriers that need to be overcome for the medical profession to continue to perform to its highest ability and safeguard patient care. In the final chapter, we look further at how we and others might overcome these barriers to good medical practice that cause variation, and we discuss where action needs to be taken to meet the existing challenges we have identified and those of the future.

## Chapter 3: A note on data

This chapter uses data about decisions at various stages of our fitness to practise procedures between 2007 and 2011. These cases were either reported to us between 1 January 2007 and 31 December 2011, or were concluded between 1 January 2007 and 31 December 2011.

We have compared complaints data across doctors' characteristics and working practices, to see if there was any difference in either the volume or the types of complaint relative to these different characteristics. As with chapter 2, it is important to note that we have looked at each of these characteristics in isolation. So, while we can highlight interesting findings and broad outcomes, we cannot draw conclusions about causality.

### Four country analysis

Comparative analysis of complaints across England, Northern Ireland, Scotland and Wales was based on fitness to practise data and compared with population figures from the Office for National Statistics (ONS). Regional analysis was completed using the number of doctors working in each geographic region; this information was taken from health workforce statistics reports for 2011.

### Organisational size analysis

For the analysis comparing complaints against organisation size, we used the annual snapshot of the number of doctors within NHS acute trusts in England as a proxy for size of organisation. The data came from the NHS Information Centre for health and social care and were valid as at 30 September 2011.

The upper and lower bounds for the hospital size groups were selected to ensure a reasonable number of trusts within each group.

### Analysis based on the GMC national training survey data

This analysis was based on the 2011 and 2012 national training surveys, which had response rates of 87% and 95% respectively. The trainee population was defined as all trainees in post within the GMC approved programmes, including Academic Clinical Fellowship and Clinical Lecturer and Foundation Programmes, on the census date. This will have excluded trainees who were on maternity leave or out of programme at the time of the census.

The national training survey data look specifically at work patterns of trainee doctors, team work and learning opportunities, handling of critical events, and the correlation between indicators from the surveys and the numbers of complaints and allegations made about doctors on a local education provider level.

### Analysis based on NHS Staff Surveys

The 2011 NHS Staff Survey in England, published on 21 March 2012, provides aggregated data at NHS provider level in terms of staff numbers, age grouping and ethnicities of employees, in addition to the satisfaction levels of staff across each provider.

It was not possible to distinguish between medical and dental staff in the survey results so data used refer to all medical and dental staff.

The NHS Scotland Staff Survey is carried out every two years. The 2010 survey results were published on 31 January 2011.

# Chapter 4: Overcoming barriers to good medical practice

## Section 1: The state of medical education and practice in the UK

Doctors remain the most trusted profession<sup>294</sup> in the UK and students at home and abroad continue to want to learn, train and practise here. There were almost 246,000 doctors on the register in 2011, and only a small number fell seriously short of the standards expected of them. That is not to say we should be satisfied with the overall standards – there remains too much variation in outcomes, some of it unexplained, and we know that as well as all the immense good that is produced by medical practice there can also be avoidable harm. Nevertheless this wider picture should be seen within a context of changing NHS structures, rising demand, pressure on resources and the ongoing evolution of new technology and treatments.

Overall, the state of medical education and practice in the UK should be a cause for celebration while never forgetting that there are further opportunities for improvement.

We set out what is expected of doctors in our core guidance, *Good Medical Practice*, which is being updated this year. Clear and respected standards are crucial to good medical practice, and we will take action against doctors who fail to meet these standards so that patients are protected. But this is only one part of the story. Doctors also need to hold and exhibit the personal values expected of their role and work in environments that foster good medical practice.

We are committed to supporting doctors to provide the best possible care and to reduce the number who struggle to meet our standards. This report explores some of the evidence around variation in medical education and practice. We have also identified some potential barriers to good medical practice that may be overcome with the right evidence, knowledge and support.

## Section 2: The size and shape of the medical workforce

The speed of change in healthcare and service configuration, alongside evolving healthcare needs and the expectation of those within the profession, calls for more flexibility in the delivery, structure and content of postgraduate medical education and training.

### The case for change for greater flexibility in training and career paths

There are fundamental changes in the make-up of the medical register. For example, both the number and proportion of female doctors continue to increase relative to men. In 2011, the number of women on the register exceeded 100,000 for the first time. Both male and female doctors have changing expectations and lifestyles from what went before.

Alongside this, the population's health care needs are shifting, and advances in medical practice mean that different knowledge, skills and ways of working are required.

A key response to these trends is greater flexibility in training and career paths. The case for change has been made for some time and it is becoming pressing. A lack of flexibility may, in particular, hinder career progression for some doctors who may not wish, or be able, to work full time. Furthermore, it hinders the medical profession's ability to respond to demand for different skills and knowledge arising from changing patient needs. And with the prospect of medical careers becoming even longer, it makes sense to consider how we can achieve the best possible fit between patients' and service needs. This is in the context of a 24/7 NHS and doctors' own evolving preferences and capabilities.

### We may be reaching the peak in the number of licensed doctors

We have continued to see an increase in the number of doctors joining the register and holding a licence to practise. However, this rise may be coming to an end, partly because of the introduction of revalidation. Doctors not in regular practice, such as older doctors who have passed retirement age, may choose not to retain their licence, as this will involve having regular appraisals to demonstrate their ongoing fitness to practise. Additionally, as budgets in the health service become constrained, the opportunities for overseas doctors to find work in the UK may decline.

### There are changing patterns in the migration of doctors who come to work in the UK

More than a third of doctors practising in the UK qualified overseas, but where they qualified from is changing. Although small, year on year these changes will lead to a significant alteration in the make-up of the medical profession across the UK. In particular this will mean fewer doctors coming to the UK from India and increasing numbers coming from the EEA generally and from eastern Europe in particular.

The diverse profile of doctors working in the UK brings potential advantages in terms experiences and background that resonate with the diverse population of patients. But it also brings challenges, not least in making sure that doctors interpret and apply our standards consistently, irrespective of where or when they trained.

### Recruitment to specialties

We continue to find a rising concern about the match between specialties that doctors wish to go into and areas of practice where patient need is greatest.

There are important questions about the appropriate balance between specialists and generalists, and whether we have enough doctors in the right specialties to cope with an ageing population living with multiple, long-term conditions.

Generalists practising today need to be equipped to deal with a varied case-mix and more complex patient needs. Specialists, too, need to be skilled in understanding patients' needs that extend beyond their immediate sphere of expertise.

There are also issues with recruitment; in particular, some areas (often those that are rural and remote) face challenges with attracting sufficient numbers of doctors with the right skills mix to meet local need.

### Action

The changes to the medical profession that we set out in this document will not simply be of interest to doctors. The profession maintains its trusted position by evolving its relationship with the public. As the profession changes, so must its engagement with wider society. There needs to be a shared understanding between governments, the profession and the public about what is expected of our doctors and what support is required to meet those expectations.

Of central importance is the increasing need for flexibility within medical careers to accommodate the changing needs of doctors in training, patients and healthcare providers. Doctors in training need more information about their career prospects to help them make decisions about their future role and place of work, based not just on their skills and ambitions, but on the needs of society and the gaps that exist in service provision.

## Section 3: The rising tide of complaints

### The number of complaints about doctors continues to rise

We continue to see a year-on-year increase in the number of complaints about doctors, particularly from patients and their relatives. Of course these represent a very small fraction of the millions of interactions between doctors and patients and must be seen in context. Nevertheless, we should be able to learn from the nature of these complaints and what they signify. The issues that patients complained about most in 2011 were around how their doctors related to them. This is a significant issue for employers and the profession and sits at the heart of the compact between doctors and patients.

### Complaints may be driven by a variety of complex factors

The increase in complaints about doctors does not on its own show that standards are declining – it is likely that it reflects changing attitudes and expectations of patients and relatives as well as better clinical governance procedures. It is also worth noting that many complaints to the GMC are not taken forward because they do not raise a question about the doctor's fitness to practise.

### A rise in complaints is not limited to doctors

There has been a rise in complaints across most health professions in the NHS and similar trends in other countries. However, it is striking that doctors were more complained about than other health professionals in the NHS in England and Wales in 2011.

### Complaints from patients are increasing

We need to explore in more depth the pattern of complaints from patients. This includes understanding any barriers that particular groups of patients may face in complaining, the difficulties inherent in navigating through the complaints system and the environments in which patients feel unable to complain.

We also need to better understand what support doctors need with treating particular groups of patients, such as elderly people and people with mental health problems. We and the profession need to be more active in seeking to understand what can be done to avoid a complaint in the first place.

**Action**

The rise in the number of complaints in recent years means that the likelihood that we will investigate a complaint about a doctor has increased from one in 68 to one in 64 in a year. That in turn could change the relationship we have with the medical profession as more doctors come into contact with us through our investigation work. We need to reflect on this and take steps to ensure that while the focus must always be on patient safety, we do what we can to reduce the trauma for everyone involved as well as cutting the time taken in handling cases.

The rising number of complaints to the GMC may represent a broader change in the relationship between doctors and patients. This may require a wider debate to understand changing expectations of the standards expected of doctors.

For the GMC, the immediate challenge is to push ahead with our reform programme to handle complaints as best we can while continuing to develop our understanding of what might lead to a complaint and what relevant and targeted support doctors need to demonstrate good medical practice. We now have a team of employer liaison advisers in place across the UK who help employers understand what they need to do if they have concerns about a doctor, including advising on when to refer a case to the GMC.

We are commissioning further research to help identify what factors might be driving this increase in complaints, particularly those from members of the public. At the same time we need to understand more about which groups of patients complain to see if there are common themes such as who they are, what they complain about, and the environment from which those concerns arise.

## Section 4: Tailoring support for doctors across their career

We have found a clear change in the pattern of complaints over the course of doctors' careers – both in the chance of them being complained about, and the nature of that complaint. Data from medical schools show that problems can emerge even while students are completing their undergraduate degrees.

### Place of primary medical qualification

Where in the world a doctor qualified affects how they understand our standards and the way they practise medicine.

In this report we have shown that, across all age groups, doctors who qualified outside the UK were proportionally more likely to be investigated about maintaining good medical practice than doctors who graduated from a UK medical school. A larger proportion of complaints about these doctors was also investigated immediately and sent to a fitness to practise panel, although they were more likely to be found not impaired and the case closed with no further action.

### Patterns of complaints change across the medical career

Once registered, newly qualified doctors were proportionally more likely to be investigated about probity than any other allegation, although of course this could reflect the fact that they are proportionally less likely to be investigated about clinical care issues than older doctors. At the end of training, there was an increase in issues related to clinical care and relationships with patients.

We found that a doctor's specialty also affected the volume and type of complaints they faced. For example, psychiatrists, obstetricians and gynaecologists, surgeons and GPs were all overrepresented in complaints about relationships with patients.

### Health problems

Although the number of complaints relating to doctors' health was small, of those who did have illnesses or conditions that affected their work, the vast majority were related to alcohol and substance misuse, followed by mental health issues. The pattern of concerns altered at different career stages.

### Tailored support and continuing professional development

The evidence discussed in this report highlights the critical importance of continuing professional development, and the need to ensure that all doctors have regular access to training and development.

The impending introduction of revalidation has provided a focus on clinical governance and support for doctors through appraisals. These appraisals, if carried out well, will be useful as they will demonstrate a doctor's fitness to practise and will provide better data on their support needs. This will be of particular advantage for those who have had fewer opportunities for appraisal in the past, such as locum and specialty doctors. It will be important that employers and contractors provide these doctors with the support they need in collecting information about their practice and giving them the space to develop professionally.

Employers have a particular responsibility in tailoring support and promoting continuing professional development, as do the medical royal colleges and specialist organisations that advise and support doctors.

The GMC is committed to building stronger partnerships with these organisations to help disseminate our standards and guidance. We recognise too that advice and guidance for doctors needs to be more targeted and available to doctors when they need it. In the past year, we launched a website to help doctors access our guidance via mobile devices in their day-to-day work.

We also need a better understanding as to why the number and type of complaints varies between specialties, and what action is needed to target the areas of practice that receive more complaints.

#### Action

In the past the GMC's focus has been largely devoted to investigating complaints about doctors – in future it also needs to make sure that doctors have tailored support to help them overcome the challenges they face at different stages of their career.

To help doctors new to practice in the UK, we will pilot an induction scheme from the end of this year. This will eventually be available to all doctors new to practice and will help them understand the standards expected of them.

Working with others we also have a responsibility to widen our engagement with doctors to understand how the standards we set can be applied in a meaningful way to their day-to-day work. This will involve partnerships with the medical royal colleges, specialist societies and employers, who will also need to provide more guidance and advice relevant to their members or employees.

## Section 5: Organisational factors affecting performance

Good medical practice requires working environments that foster a shared responsibility for achieving high standards.

We have looked at where doctors work. As with so often in the history of the NHS, many of these settings are in flux, with changes in organisation of health services. This report has provided more evidence that standards of practice can vary depending on the environment in which doctors work. This is not surprising – reports into failures of care have all pointed to the fundamental role played by systemic and institutional problems when things have gone wrong. Working practices, workforce issues and organisational culture all contribute to a doctor's ability to provide good medical practice.

### Culture within organisations

For the most part, doctors work in contexts that encourage and support high standards. But this is not always the case.

At worst, there can be a disconnect between the environment, the system and the doctors themselves. This can lead to a culture in which poor standards are accepted and doctors fail to raise concerns about patient safety. As this report is published, the final report from the Mid Staffordshire NHS Foundation Trust Public Inquiry is awaited.

The evidence from many sources suggests that doctors need to work in organisations that have effective clinical governance arrangements that foster high standards of medical professionalism.

We believe our data – from the register, from our educational work and our investigations into poor practice – can help to identify the barriers to good medical practice. This in turn should help prevent problems occurring in the first place. However, we recognise we need to understand more about what insight our data can provide.

### The role of leadership and engagement

Doctors have a vital leadership role in ensuring high quality patient care. Doctors have not always acted when they have become aware of poor care or acts which undermine the dignity of patients. A clear message from the past year is that doctors must act when they become aware of poor standards. This requires all doctors to be leaders beyond the confines of direct medical practice. And they need to be supported in assuming this role.

Earlier this year, we published revised guidance on leadership and management for doctors. There are many examples of good practice in leadership and training, such as inter-professional training, junior doctors and management trainees learning together, and more formal leadership schemes like the clinical fellowship scheme run by the Department of Health in England. But such schemes, opportunities and practices need to be more widespread so that management and leadership skills are instilled at every stage of a doctor's career, from undergraduate medical education and throughout their training and continuing professional development.

Together with the profession we need to be forthright in setting the expectation that all doctors must accept responsibility for the wider context in which care is delivered.

There is a need too to consider what more can be done in both undergraduate and postgraduate education to develop leadership skills in the next generation of doctors who will work in different ways and different settings from their predecessors.

### Working patterns

A wealth of evidence shows that patients suffer when services are covered by fewer senior doctors. Organisations must find ways to respond to reduced working hours and other workforce challenges without compromising patient care and doctors' training. Doctors must not be under pressure to work beyond their competence.

It is increasingly difficult to ignore growing evidence supporting a move to seven-day working, so that patient care and safety are not compromised at times when fewer senior doctors are available. Clearly, service organisation is a matter for individual healthcare providers, but they have a responsibility to ensure that the right medical staff are in place to provide safe care, and that doctors in training are not left feeling vulnerable and exposed. There will be changes too for the profession itself, as doctors may need to work more flexibly to meet service needs, including at weekends. In short, there is an overwhelming need to challenge working patterns that harm patient outcomes.

### Action

There needs to be a better understanding of the environment in which doctors work and train, and its impact on ensuring high standards of practice and improving patient safety.

At a time when the health service is under significant financial pressure and is undergoing large-scale reorganisation, clearly this will be difficult because doctors and all health professionals will be placed under many, often conflicting, pressures. In view of this pressure, doctors must be able to speak out if they see evidence that patient care is being, or could potentially be, put at risk. We are planning to launch a targeted helpline that will enable doctors to provide details of concerns if they believe they could be victimised if they report these locally.

There is also more that the GMC can do to understand better, and in more detail, how organisational factors can affect medical practice. In this report, we have started to explore how characteristics like organisational size, training and supervision might relate to trends in areas such as complaints. As we continue to analyse fitness to practise activity by the location of the incident, we should be able to identify trends at a regional and a trust or board level. This in turn should help inform our understanding of organisational factors that may affect the quality of medical practice.

## Conclusion

*The state of medical education and practice in the UK: 2012* seeks to contribute to a wider understanding of the medical profession. We have used our data and data from other sources to reflect on the medical profession as it is today and what it might need to become in the future. In doing this, we aim to promote discussion and debate, and ultimately contribute to better medical care for patients throughout the UK.

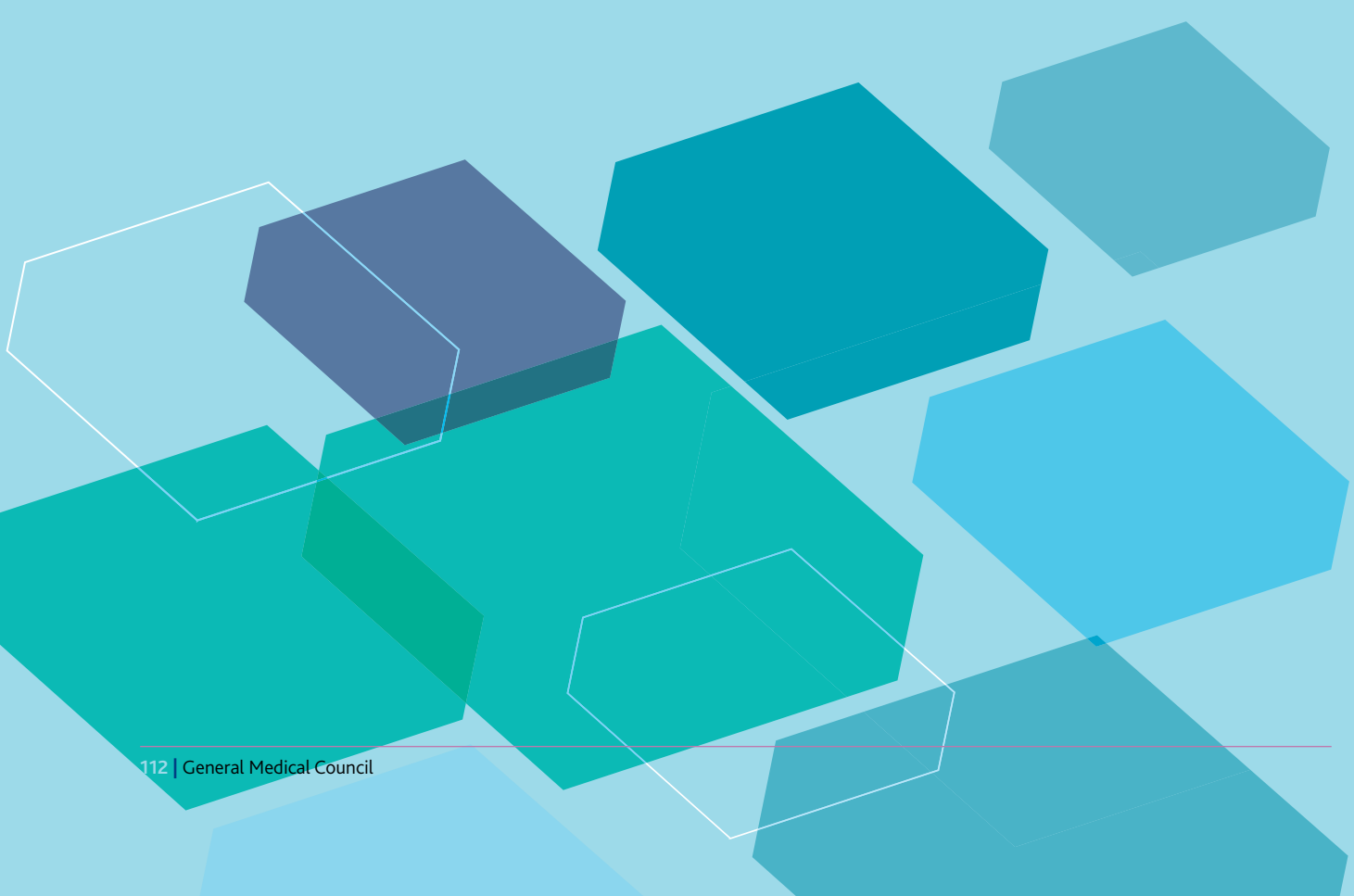
This year, we have looked in more detail at the enablers and barriers to good medical practice. No two doctors are the same, and each interaction with a patient is different. The standards we set are not applied in a single homogenous setting. Doctors' personal values, their interaction with their peers and their working environments seem as likely to affect their practice as the expectations we set. As such we need to recognise the limits of what a national regulator can achieve.

But, in the future, we will have to change the way we engage with doctors, as well as those who support their practice and employ them. For every doctor it should become an ongoing relationship, providing them with guidance and support that is relevant to their day-to-day practice.

Employers and the government also need to play their part by recognising the changing nature of the profession and enabling greater flexibility in both career pathways and working arrangements.

We believe there is a need for a debate, for us as a regulator, the profession, employers of doctors, medical royal colleges and society more generally about the role and potential of medical practice in the UK. We hope that this report will help stimulate discussions on what improvements can be made and what action is needed.

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# Glossary



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<b>Academic clinical fellowship (ACF)</b>	An ACF combines medical training with academic training. An ACF programme will typically run over three years. During this time the ACF will rotate through clinical posts to develop competencies relevant to their level of training.
<b>Academy of Medical Royal Colleges</b>	The Academy promotes and coordinates the work of the medical royal colleges and faculties.
<b>Allegations</b>	Allegations are attached to any complaint that goes forward to be investigated. They describe the nature of the concern about the doctor's fitness to practise. Many cases involve more than one allegation.
<b>Annual Review of Competence Progression (ARCP)</b>	The ARCP, introduced in August 2007, is a postgraduate deanery process which scrutinises each postgraduate doctor in training's suitability to progress to the next stage of, or to complete, a training programme. It is usually held annually, but some specialties have more frequent reviews in the early years of training. Foundation Programmes have a similar annual review process. The review panel, which includes the Programme Director, bases its recommendations on evidence in the doctor in training's portfolio of experience and competences gained, together with the reports of the supervisor(s). The ARCP is not in itself an assessment exercise.
<b>Annual specialty report (ASR)</b>	The ASR is the mechanism by which medical royal colleges and faculties provide assurance to the GMC and the public that they are driving the quality of training and the delivery of curricula in line with the GMC's standards for curricula and assessment systems.
<b>Black and minority ethnic (BME)</b>	In this report, the term 'BME' refers to people who have not defined themselves as being white, using the 2001 census definitions.
<b>British Medical Association (BMA)</b>	The professional association for doctors in the UK. The BMA is an independent trade union, which acts for individual doctors and the collective interests of doctors.
<b>Care Quality Commission (CQC)</b>	The independent regulator of health and social care in England. The CQC looks at the joined up picture of health and social care. It aims to ensure better care for everyone in hospital, in a care home and at home. It focuses on the system as a whole rather than the actions of individual professionals.
<b>Centre for Workforce Intelligence (CfWI)</b>	The CfWI is responsible for NHS workforce (ie staff) planning and development in England. The CfWI models future workforce needs so that the NHS and social care providers can plan for them.
<b>Certificate of Completion of Training (CCT)</b>	A CCT is awarded by the GMC to doctors in training who satisfactorily complete their training in an approved specialty (including general practice) curriculum. Some doctors in training follow specialty training in two specialties and are thus awarded with a dual CCT if they satisfactorily complete both curricula.

**Certificate of Eligibility for General Practice Registration (CEGPR)**

This is awarded to doctors who demonstrate that their GP training or qualifications, together with their experience, are equivalent to the GMC approved CCT curriculum. This certificate enables those with full registration to be entered onto the GMC GP Register (see CESR below for more details).

**Certificate of Eligibility for Specialist Registration (CESR)**

Doctors are eligible for a CESR if they have:

- a. undertaken specialist training or obtained specialist qualifications in a UK recognised specialty (approved by the GMC for UK training programmes), which are determined by the GMC to be equivalent to a CCT in that specialty; or
- b. undertaken specialist training or obtained specialist qualifications outside the UK in a specialty not recognised in the UK, which satisfy the GMC that they give a level of knowledge and skill consistent with practice as a consultant in any of the UK health services; or
- c. knowledge of, or experience in, any medical specialty derived from academic or research work which satisfies the GMC that they have a level of knowledge and skill consistent with practice as a consultant in any of the UK health services.

**Clinical Commissioning Groups (CCGs)**

From April 2013, CCGs in England will have responsibility for commissioning healthcare to meet the needs of a defined local population, a responsibility previously held by primary care trusts in England. All general practices will be required to become members of a CCG, which will also include other health professionals. CCGs will hold real budgets and will commission the majority of healthcare services in England, except for primary care and some specialised services, which will be commissioned by the National Commissioning Board. CCGs will be accountable to the National Commissioning Board for ensuring that commissioned services meet required quality standards and patient outcomes.

**Clinical supervision**

This is a formal way of supporting doctors' learning. Every doctor in training must have a named clinical supervisor and a named educational supervisor (although the two roles can be held by the same individual). The overall aim of clinical supervision is to ensure that the doctor is safe to carry out the clinical work they are expected to do within the department, and that they are continuing to develop their knowledge and skills.

**Commission on Generalism**

The Independent Commission on Generalism was established by the Royal College of General Practitioners in partnership with the Health Foundation in March 2011 to examine the contribution and role of General Practitioners and generalists in the healthcare system.

**Comorbidity**

Comorbidity refers to the existence of two or more diseases or conditions in the same individual at the same time.

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<b>Complaints</b>	Complaints are defined as information received by the GMC that may raise concerns about a doctor's fitness to practise. They may come from a member of the public, an employer or another public body.
<b>Continuing professional development (CPD)</b>	CPD refers to any learning undertaken outside undergraduate education and postgraduate training which helps to maintain and improve performance. In the case of doctors, it covers the development of knowledge, skills, attitudes and behaviours across all areas of medical practice. It includes all learning activities, both formal and informal, by which doctors maintain and develop the quality of their professional work.
<b>Core specialty training</b>	<p>Training for some medical specialties is broken down into two parts: core specialty training and higher specialty training. For most such specialties, core training lasts for an indicative two years. Trainees then compete for places on higher specialty training programmes. Core specialty training applies to:</p> <ol style="list-style-type: none"><li>medical training, leading to competitive entry to 28 medical specialties</li><li>surgical training, leading to competitive entry to nine surgical specialties</li><li>psychiatry</li><li>anaesthetics</li><li>emergency medicine</li><li>trauma and orthopaedics (for some doctors in training).</li></ol>
<b>Employer Liaison Service</b>	The GMC employs Employer Liaison Advisers (ELAs) who have fitness to practise expertise and who work with medical directors in both the NHS and the independent sector to support them in dealing with concerns about doctors, specifically fitness to practise and revalidation. These advisers make up the GMC's Employer Liaison Service.
<b>Equivalence routes</b>	Certificates of Completion of Training (CCTs) are only issued to doctors who complete full GMC approved training programmes. Some doctors gain all the same experience and training in other ways, and they can apply to join the Specialist or GP Registers through equivalence routes. They can do this by obtaining either a Certificate of Eligibility for Specialist Registration (CESR) or a Certificate of Eligibility for GP Registration (CEGPR). An applicant must provide a portfolio of evidence that demonstrates that their training, qualifications and experience meet the GMC's standards. See CESR and CEGPR above.
<b>Erasure</b>	A doctor's name can be erased from the medical register so that they will not be able to work as a doctor in the UK. This is the most serious outcome of our fitness to practise procedures. However, doctors can also apply for voluntary erasure for all kinds of reasons not associated with their fitness to practise. (See voluntary erasure below.)

<b>European Economic Area (EEA)</b>	The EEA includes all the member states of the European Union and three additional countries which are members of the European Free Trade Association: Iceland, Norway and Liechtenstein.
<b>European Network of Medical Competent Authorities (ENMCA)</b>	Set up in 2010, ENMCA is coordinated by the GMC, the Bundesärztekammer (BÄK-GMA) and the French Conseil national de l'Ordre des médecins (CNOM). It brings together European competent authorities responsible for the recognition of medical qualifications, in line with Directive 2005/36/EC on the recognition of professional qualifications.
<b>The Federation of State Medical Boards (FSMB)</b>	The FSMB is a national non-profit organization representing the 70 medical and osteopathic boards of the United States of America and its territories.
<b>Fitness to practise</b>	<p>A doctor's fitness to practise medicine is their ability, or willingness, to provide safe, high quality care.</p> <p><i>Good Medical Practice</i> sets out the standards we expect of doctors. We measure a doctor's fitness to practise against these standards. We take action through our fitness to practise procedures where there has been a serious or persistent breach of our standards.</p>
<b>Foundation training</b>	See Foundation Programme.
<b>Foundation Programme</b>	A two-year (whole time equivalent - wte) generic medical training programme, which bridges medical school and specialist training. Foundation year 1 (F1) builds on the learning, skills and knowledge obtained during undergraduate education. F1 trainees are provisionally registered with the GMC meaning they can carry out a limited number of procedures and have to work under close supervision. The satisfactory completion of year 1 is associated with a recommendation for full registration with the GMC and the satisfactory completion of year 2 is associated with the award of a Foundation Achievement of Competence Document (FACD), which is required for entry to GP and specialty training programmes or posts in the UK.
<b>Good Medical Practice</b>	<p><i>Good Medical Practice</i> is our core guidance on what makes a good doctor. It sets out the principles and values we believe make up good medical practice and it is against these that doctors' fitness to practise medicine is assessed.</p> <p>The guidance is written for doctors to follow in their work, but it also lets patients know what they can expect from doctors.</p>

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<b>GP Register</b>	The GP Register includes the names of all those doctors who are eligible to be included on the register, and to work as GPs in the NHS, provided they also gain access to a performers' list.
<b>GP trainee</b>	A doctor on a GMC approved training programme to become a GP. On successful completion of GP training, doctors receive a Certificate of Completion of GP Training (CCTGP) and can apply to join the GP Register.
<b>Health and Social Care Transparency Panel in England</b>	This panel, chaired by Earl Howe for the Department of Health, was set up in 2011. It aims to inform medical regulatory authorities worldwide.
<b>International Medical Graduate (IMG)</b>	IMGs are doctors who do not benefit from EC rights and are: <ul style="list-style-type: none"><li>■ Nationals of a country outside the UK, EEA or Switzerland who graduated from a medical school outside the UK or</li><li>■ UK nationals who have graduated from a medical school outside the UK, EEA or Switzerland.</li></ul>
<b>Licensing/licence to practise</b>	<p>Doctors must be both registered with the GMC and hold a licence to practise to work in the UK. Doctors may choose to be registered without a licence to practise medicine if they are, for example, working overseas but want to show they are in good standing with the UK medical regulator.</p> <p>Licensing was introduced in 2009. It is the first step towards revalidation, which will involve doctors renewing their licence by showing they are up to date and fit to practise.</p>
<b>Locum Appointment for Service (LAS)</b>	Short-term appointment used to fill a service gap. Experience in such posts cannot count towards a CCT but may, in certain circumstances, be used as evidence for a CESR application
<b>Locum Appointment for Training (LAT)</b>	A short-term appointment to fill a gap in a training programme. The minimum duration is three months (wte) and a LAT should not normally last more than 12 months (wte). Providing the post and experience acquired can be seen to contribute demonstrably towards progress through a programme, the LAT can be used prospectively to count toward a CCT.
<b>Medical register</b>	The medical register is publicly available and searchable on our website. It lists all doctors registered with the GMC. All doctors wanting to practise in the UK must be registered with the GMC and hold a licence to practise.
<b>Medical School Annual Return (MSAR)</b>	The MSAR is the mechanism by which medical schools provide assurance to the GMC and public that they are managing the quality of undergraduate medical programmes in line with our standards. These standards are set out in Tomorrow's Doctors (2009).

**Medical royal colleges and faculties**

Medical royal colleges and faculties are responsible for:

- developing the curricula for specialty training
- developing the assessment systems and examining trainees
- recommending to the GMC when a trainee has successfully completed training
- participating in the evaluation of doctors applying for CESR or CEGPR
- providing education for their members throughout the course of their career
- producing clinical guidelines and reports on elements of service and service provision
- promoting research and clinical audit
- acting as an advisory body to the departments of health, health authorities, trusts, hospitals and other professional bodies.

**Medical Schools Council (MSC)**

The MSC represents the interests of the UK's medical schools. It is made up of the heads or deans of the 32 UK undergraduate medical schools, plus the London School of Hygiene and Tropical Medicine (postgraduate).

**Medical Students Mental Health Operational Group**

The group is overseeing the commissioning of research into the mental health of medical students. It is a joint project with the Medical Schools Council which the GMC is leading on, and feeds into the wider review of health and disability in medical education and training.

**National Clinical Assessment Service (NCAS)**

NCAS provides support to healthcare organisations and individual practitioners in England, Northern Ireland and Wales to resolve performance concerns about doctors, dentists and pharmacists. It makes recommendations to support their return to safe practice.

**National training surveys**

Each year the GMC conducts surveys of doctors in training in the UK. The results help to guide our quality assurance work and are an important source of evidence about the quality of medical education.

**Nursing and Midwifery Council (NMC)**

The NMC is the regulator for the 660,000 registered nurses and midwives in the UK.

**Performers' List**

All GPs who want to provide NHS Primary Care services in England must have their name included on a Primary Care Trust's Performers' List, in accordance with the NHS (Performers Lists) Regulations 2004. Separate provision exists for Scotland, Wales and Northern Ireland.

**Persons acting in a public capacity (PAPC)**

An individual acting on behalf of an organisation.

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<b>The Practitioner Health Programme</b>	The NHS Practitioner Health Programme is a free, confidential service for doctors and dentists living in London, Brighton and Hove who have mental or physical health concerns and/or addiction problems.
<b>Primary medical qualification (PMQ)</b>	The qualification gained on successful completion of an undergraduate (or graduate) medical degree.
<b>Postgraduate deanery</b>	Deaneries are regional bodies that oversee the delivery of postgraduate medical education, including the continuing professional development of all doctors and dentists.
<b>Postgraduate Medical Education and Training Board (PMETB)</b>	PMETB was previously responsible for quality assuring postgraduate medical education and training in the UK. PMETB merged with the GMC in April 2010.
<b>Regional Liaison Service</b>	The GMC's Regional Liaison Service works with groups representing patients and doctors, medical schools and students across England. It has a team of Regional Liaison Advisers who work with postgraduate deans, medical schools, local medical committees and other local bodies to strengthen our relationship with all those who have an interest in work.
<b>Responsible officer</b>	<p>Responsible officers will have a key role in revalidation (see below). They will make a recommendation to the GMC, usually every five years, about whether each doctor in their organisation should be revalidated.</p> <p>Responsible officers will also ensure that systems of clinical governance and appraisal in their organisation are working and are appropriate for revalidation.</p> <p>Responsible officers must be licensed medical practitioners, and in most cases will be the medical director within a healthcare organisation. They are responsible for the doctors employed by, or contracted to, the designated body or organisation, or who have some other prescribed link, for example through membership. Each doctor will only link to one responsible officer.</p>
<b>Revalidation</b>	<p>Revalidation is the process by which licensed doctors will, from the end of 2012, regularly demonstrate to the GMC that they are up to date and fit to practise.</p> <p>It will be based on existing annual appraisal systems. These are being strengthened to include robust supporting information to show how doctors are demonstrating Good Medical Practice in their daily practice. This includes evidence of how they are keeping their knowledge and skills up to date by addressing any development needs as they arise.</p> <p>At the end of each revalidation cycle, normally every five years, responsible officers will make a recommendation to the GMC about whether each doctor should be revalidated based on feedback from their appraisals throughout the cycle.</p>

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**Shape of Medical Training Review**

This independent review, chaired by Professor David Greenaway, is considering areas such as the proper balance between specialisation and generalism in medicine and how to balance the workforce demands of health services with the learning needs of doctors in training. It is due to publish its recommendations in 2013.

**Specialist Register**

The Specialist Register lists all doctors who have completed their specialist training and are eligible to be considered for appointment as consultants in the NHS.

**Specialty**

Specialties are areas of medicine that require particular sets of knowledge, skills and experience, for example Paediatrics is a specialty focusing on the medical care of children. Once a doctor has completed their Foundation training, they can apply for training in a particular specialty. There are currently 61 specialties approved by the GMC, and 36 sub-specialties within those.

**Specialty doctors**

Specialty doctors are employed by the NHS in service posts. They are not consultants and are not in formal training programmes to become so. These doctors work under the supervision of a consultant. Specialty doctors were previously known as non consultant career grade doctors (NCCG) and also staff and associate specialist, or 'SAS' doctors.

**Suspension**

Suspension is one of the most serious outcomes of our fitness to practise processes. If we suspend a doctor from the medical register they cannot practise medicine during the period of suspension.

**Undergraduate medical education**

An undergraduate degree giving an academic grounding in medicine and basic clinical skills. There are 32 medical schools in the UK. Most undergraduate medical courses in the UK last five years, but there are also some six-year courses that offer students the opportunity also to obtain a related Bachelor of Science degree. Additionally, there are four-year graduate entry programmes for students who gained a first degree in another subject.

**Undertakings**

Undertakings are a possible outcome of our fitness to practise procedures. They are agreed between the GMC and the doctor about the doctor's future practise, which could include restricting their practise or requiring them to be supervised or undergo further training.

They allow the GMC to deal effectively with cases where problems with a doctor's work are due to a health condition. Undertakings may also be used to deal with all except the most serious performance problems which the doctor recognises and agrees to address without having to refer the case to a fitness to practise panel hearing.

**Voluntary erasure**

Doctors who no longer practise medicine in the UK, for example if they have retired from practise, have to formally apply to have their names removed from the medical register. This is known as 'voluntary erasure from the register'. In exceptional cases, a doctor may be allowed to take voluntary erasure where there are fitness to practise concerns – for example, if they are too sick to take part in a hearing or unlikely to return to medical practice.

**Working Time Regulations (WTR)**

Regulations implemented following the European Working Time Directive (2003). These prevent employees from working more than 48 hours a week, averaged over a 17-week period.

# Appendix: The medical register across the UK

**Key**

	England	Scotland	Wales	N. Ireland
<b>Total</b>	<b>183,019</b>	<b>20,151</b>	<b>10,746</b>	<b>6,674</b>
	177,659	19,373	10,400	6,454

Gender	England	Scotland	Wales	N. Ireland
<b>Male</b>	<b>103,838</b>	<b>10,458</b>	<b>6,335</b>	<b>3,544</b>
	100,710	10,025	6,109	3,419
<b>Female</b>	<b>79,181</b>	<b>9,693</b>	<b>4,411</b>	<b>3,130</b>
	76,949	9,348	4,291	3,035

Age	England	Scotland	Wales	N. Ireland
<b>Under 25</b>	<b>3,463</b>	<b>747</b>	<b>284</b>	<b>357</b>
	3,463	743	283	357
<b>25-34</b>	<b>52,284</b>	<b>5,881</b>	<b>2,824</b>	<b>2,298</b>
	51,581	5,772	2,778	2,251
<b>35-44</b>	<b>52,941</b>	<b>5,373</b>	<b>2,968</b>	<b>1,602</b>
	52,418	5,321	2,948	1,583
<b>45-54</b>	<b>38,642</b>	<b>3,830</b>	<b>2,231</b>	<b>793</b>
	38,220	3,789	2,213	782
<b>55-64</b>	<b>21,724</b>	<b>2,139</b>	<b>1,214</b>	<b>391</b>
	20,857	1,976	1,153	368
<b>65 and over</b>	<b>9,880</b>	<b>858</b>	<b>488</b>	<b>194</b>
	7,767	522	366	122
<b>Unknown</b>	<b>4,085</b>	<b>1,323</b>	<b>737</b>	<b>1,039</b>
	3,353	1,250	659	991

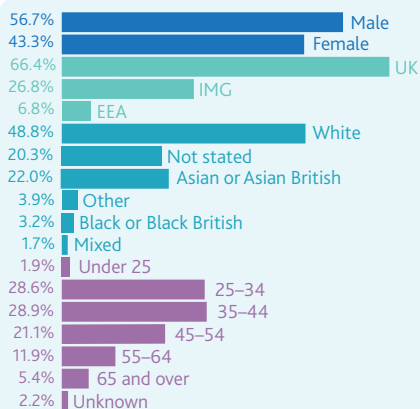
----- Registered doctors 2011  
 ----- Registered and licensed doctors 2011

PMQ	England	Scotland	Wales	N. Ireland
<b>UK</b>	<b>121,456</b>	<b>16,731</b>	<b>7,325</b>	<b>5,577</b>
	117,260	16,010	7,034	5,393
<b>IMG</b>	<b>49,040</b>	<b>2,512</b>	<b>2,817</b>	<b>478</b>
	48,132	2,466	2,770	468
<b>EEA</b>	<b>12,523</b>	<b>908</b>	<b>604</b>	<b>619</b>
	12,267	897	596	593

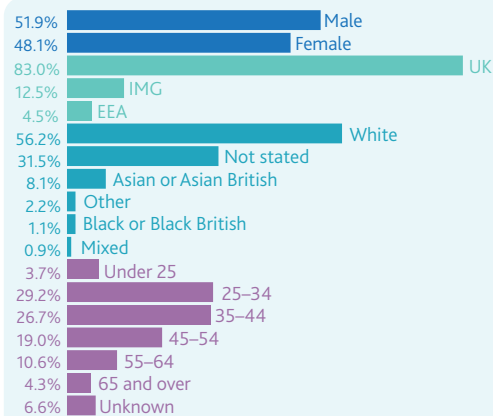
  

Ethnicity	England	Scotland	Wales	N. Ireland
<b>White</b>	<b>89,253</b>	<b>11,334</b>	<b>5,374</b>	<b>4,166</b>
	86,351	10,844	5,168	4,013
<b>Not stated</b>	<b>37,230</b>	<b>6,355</b>	<b>2,987</b>	<b>2,061</b>
	35,492	6,109	2,888	2,005
<b>Asian or Asian British</b>	<b>40,344</b>	<b>1,626</b>	<b>1,834</b>	<b>293</b>
	39,855	1,601	1,802	285
<b>Other ethnic groups</b>	<b>7,184</b>	<b>445</b>	<b>282</b>	<b>87</b>
	7,075	437	275	85
<b>Black or Black British</b>	<b>5,913</b>	<b>218</b>	<b>148</b>	<b>38</b>
	5,837	214	147	38
<b>Mixed</b>	<b>3,095</b>	<b>173</b>	<b>121</b>	<b>29</b>
	3,049	168	120	28

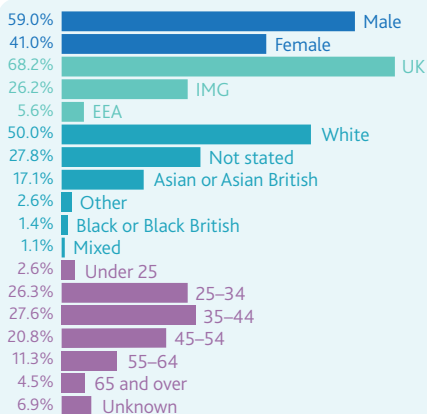
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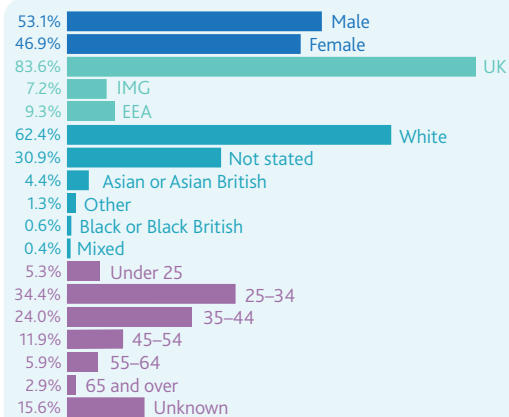
**Scotland 20,151**



**Wales 10,746**



**N. Ireland 6,674**



\*Figures exclude other non-UK, Isle of Man, Channel Islands and unspecified.

# Acknowledgements

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## **Authors**

Luke Bruce (Editor)  
Elizabeth Hopper  
Judith Hulf (Clinical Adviser)  
Nicholas Ibery (Clinical Adviser)  
Elizabeth McGrath  
Chris Nightingale  
Jacqui Thornton



Email: [gmc@gmc-uk.org](mailto:gmc@gmc-uk.org)

Website: [www.gmc-uk.org](http://www.gmc-uk.org)

Telephone: **0161 923 6602**

**General  
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