

## Summary: *The state of medical education and practice in the UK: 2012*

*The state of medical education and practice in the UK: 2012* uses data from the General Medical Council (GMC) and from others to provide a picture of the medical profession in the UK and to identify some of the barriers and enablers to good medical practice.

### Aims of the report

There is much to celebrate about the state of the medical profession in the UK: it is diverse, doctors continue to be the most trusted profession in the UK,\* and the number of doctors drawn to the GMC's attention who are falling seriously short of the standards expected of them remains very small.

But we know there is variation in how doctors practise.

This second edition of *The state of medical education and practice in the UK* starts to identify the causes of this variation. It considers what barriers doctors might face in delivering high quality care for patients and in meeting the standards set out in the GMC's core guidance *Good Medical Practice*. Some barriers to good medical practice may be individual to the doctor, whereas others can relate to the context in which doctors work.

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

### About the report

The full report covers four main areas.

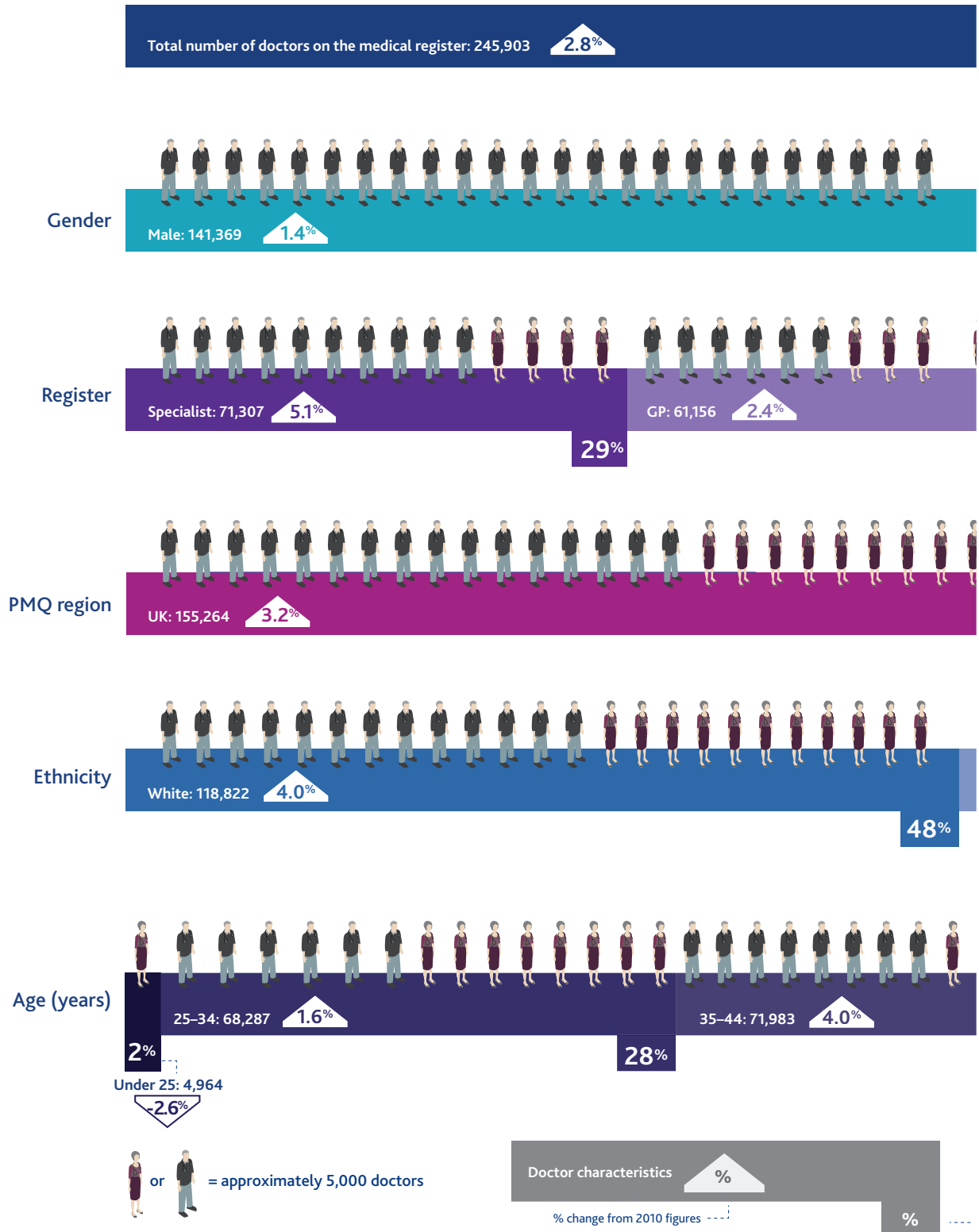
- *Changes in the medical profession since last year* (chapter 1) updates on key indicators about the profession from last year's report, and reflects on significant changes.
- *Medical practice at different stages of doctors' careers* (chapter 2) looks at how types of complaints vary over doctors' professional lives, and the importance of tailoring support for them.
- *Doctors in the workplace* (chapter 3) assesses the variability of practice across 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 ensure the profession can meet existing and future challenges and healthcare needs.

This summary provides an overview of the report's main findings and conclusions.

\* Ipsos Mori (2011) *Trust in professions 2011* London, Ipsos Mori

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

The composition of the UK's medical profession continues to change, as do the demands placed upon it. The figure below shows the breakdown of the medical register in 2011, and how it has changed since 2010.



PMQ=primary medical qualification. IMG=international medical graduate. EEA=European Economic Area.

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%

63%

EEA: 24,031

5.6%

27%

10%

Asian: 46,664

4.3%

19%

Other: 9,002

Black: 6,812

Mixed: 3,643

Not stated: 60,960

-2.2%

25%

5.7%

7.5%

8.1%

45-54: 51,764

3.9%

29%

55-64: 28,483

3.9%

21%

65+: 12,360

5%

12%

Unknown: 8,062

3%

4.8%

-7.1%

---- Proportion of the total register

## Doctors on the medical register 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 of the UK. There are changes in the countries from which doctors come to the UK to practise, with the profession shaped by external factors.

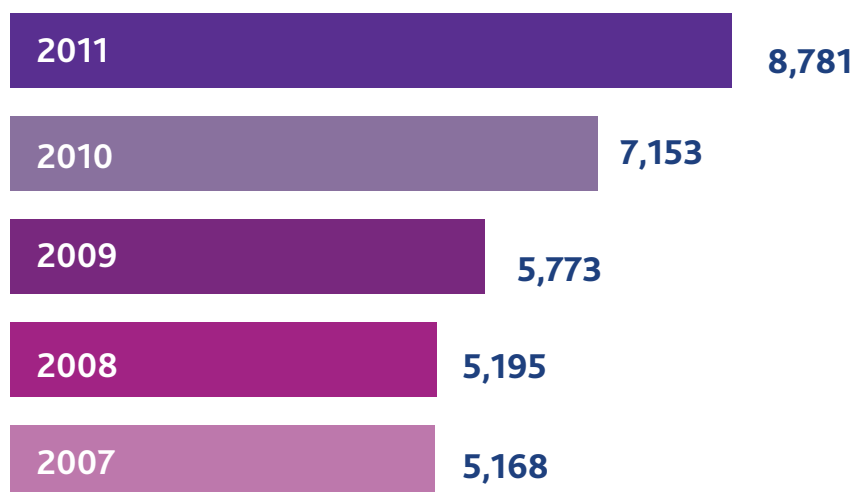
## Medical education and training

- Medical students continue to come from higher socioeconomic backgrounds. Of the 2010–11 undergraduate medical schools intake, 57% came from the top three socioeconomic groups, and 7% from the bottom three.\*
- There is a continuing debate about the distribution of doctors across specialties, particularly whether we have an appropriate balance between specialists and generalists, and if we have enough doctors in the right specialties to care for an ageing population.

## Complaints about doctors

- The number of complaints received by the GMC has continued to rise. We received 8,781 complaints in 2011, up 23% from 7,153 in 2010.
- 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 a year.
- We saw a particular increase in complaints from patients. The issues that they, as opposed to doctors, tend to complain about were the greatest areas of increase since last year. These 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.

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



\* The Cabinet Office (2012) *Fair Access to Professional Careers: A progress report* London, The Cabinet Office, p4

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

Doctors face different challenges, which might affect their fitness to practise at different stages of their careers. We and others need to understand these patterns better to identify areas where doctors may need more tailored support.

### Patterns in allegations at different stages of doctors' careers

There were three marked trends in the nature of allegations that the GMC investigated in 2011 (see the figure on page 6). As time since a doctor's qualification 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 (mainly issues relating to doctors' communication skills and how they interact with their patients).

These trends are set in the context that the GMC received proportionally more complaints about older doctors overall.

### Stages in the medical career

#### Before qualification – medical students and doctors in training

- Male medical students were more likely to face complaints about their conduct, and female medical students about their health.

#### Place of qualification

- Where in the world doctors qualified did not affect the overall likelihood of them being complained about, but it did affect the type of complaint.

- Older international medical graduate doctors were more likely to be complained about than doctors in the same age group who qualified in the UK or the European Economic Area.

#### Doctors on the GP or Specialist Register

- 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 type of complaints they faced. For example, psychiatrists, obstetricians and gynaecologists, surgeons and GPs were overrepresented in the allegations we investigated about relationships with patients.

#### Doctors in service posts

- We need to know more about the support needs of locum doctors and specialty doctors,\* who play an important role in the UK's health systems. The introduction of revalidation, the process by which licensed doctors will regularly demonstrate to the GMC that they are up to date and fit to practise, should help. As part of revalidation, planned for the end of 2012,† all doctors will need to submit a range of evidence of professional competence as part of their appraisal process.
- Revalidation should also ensure that these doctors have access to appraisals. In 2011–12, just 54% of specialty doctors had an appraisal, compared with 74% of consultants and 90% of GPs.‡ This was an improvement, however, from 2010–11, when appraisal rates for specialty doctors were just 36%.

#### Health concerns

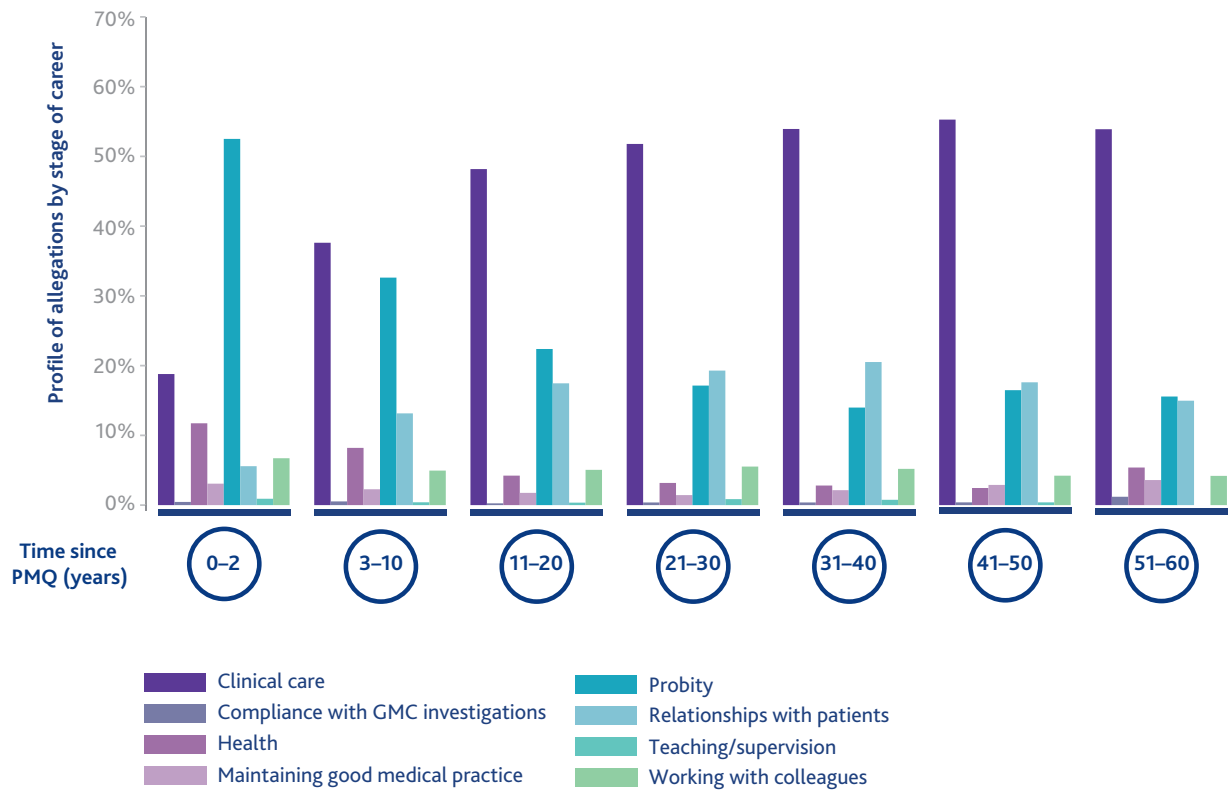
- Only a very small number of complaints were about doctors' health. However, the majority of these related to substance misuse and mental health. The type of health issues varied at different stages of doctors' careers.

\* Formerly known as staff and associate specialist 'SAS' doctors.

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

‡ NHS Revalidation Support Team (2012) *Organisational Readiness Self Assessment (ORSA) progress report* London, NHS Revalidation Support Team, p30

Distribution of allegations investigated about doctors by time since primary medical qualification (2007–11)\*



\* This analysis 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. It does not track a particular cohort of doctors over the course of their career. Neither does it 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, rather than absolute numbers of allegations investigated.

## Doctors in the workplace (chapter 3)

Medical practice is not only determined by the characteristics of individual doctors, but can be shaped and influenced by the contexts in which they work and train. We and others need to understand better how organisational issues and factors might enhance or constrain good medical practice.

### Where doctors work

- There was little difference in complaints across the four UK countries and health systems.
- There were 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.

### The organisations in which doctors work and train

- 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. Although the difference in the number of complaints per doctor between smaller and larger trusts was relatively small, there was large variation in the number of complaints per doctor across trusts in the small and medium groups.
- Workforce issues are continuing to impact on medical training and practice. There is a growing body of evidence that patient outcomes are

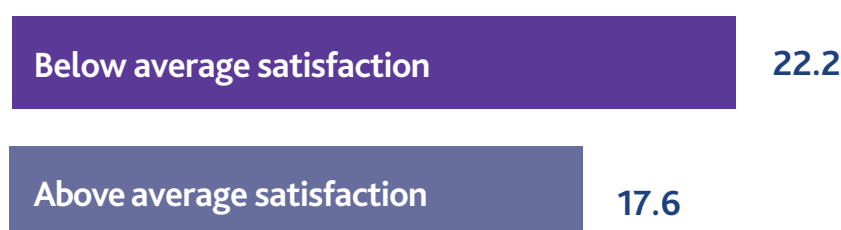
worse on evenings and weekends – times when there is less senior doctor cover. And, in some specialties, recruitment difficulties are affecting both service provision and training, particularly ensuring that doctors in training have access to adequate supervision and protected time for education.

- 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. Organisations where doctors in training reported below average satisfaction with clinical supervision in the 2011 national training survey also had a higher proportion of complaints to the GMC (see the figure below).
- 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.

### The patients who doctors treat

- There continues to be evidence of poor care in the treatment of the most vulnerable groups such as children, older people and people with learning disabilities.
- We need to understand more what drives these variations in patient experience and outcomes. This includes looking more closely for patterns and trends in complaints, so that we and others can get a clearer view on what improvements and support may be needed.

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



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

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.

The GMC is committed to supporting doctors to provide the best possible care and to reduce the number who struggle to meet our standards so that patients are protected. The main 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.

Below we set out four areas where we believe there is a need for further debate and action to address these barriers.

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

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

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

### 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 to the GMC, 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.

Read the full report and tell us what you think about our findings at [www.gmc-uk.org/somep2012](http://www.gmc-uk.org/somep2012).

Read last year's report *The state of medical education and practice in the UK: 2011* at [www.gmc-uk.org/somep2011](http://www.gmc-uk.org/somep2011).

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