

General
Medical
Council

The state of medical education and practice in the UK

2011

General
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Council

Regulating doctors
Ensuring good medical practice

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Contents

Foreword	04
Executive summary	06
Introduction	08
Chapter 1: A diverse and changing profession	14
Key information	14
Box 1: Facts for 2010	14
The medical register and licensing	15
The medical profession is highly diverse and is changing significantly	18
The number of female doctors is set to overtake male doctors	18
<i>Training and workplaces will need to accommodate shifting requirements</i>	23
The average age of doctors is falling	23
<i>The changing age demographic has implications for the profession and service delivery</i>	25
More than a third of registered doctors qualified outside of the UK	26
<i>The proportion of overseas qualified doctors in the UK has been lower in recent years</i>	27
<i>Doctors practising in the UK completed their undergraduate medical studies in a wide range of countries</i>	28
<i>Doctors who gained their PMQ overseas have a different profile by age and gender</i>	29
The medical profession is ethnically diverse	32
Doctors work in many different medical specialties, sub-specialties and areas of special interest, each with their own clinical standards	37
<i>Specialties vary by size and attract disproportionate numbers of trainees</i>	37
<i>Men and women make different specialty training choices</i>	40
Conclusion	40
A note on data	41
Chapter 2: The key role of education and training in supporting good medical practice	42
Key information	42
Box 2: The GMC's role in medical education and training	46
Good medical education is essential to good medical practice	47
<i>Medical education is being delivered in a changing environment</i>	47
Box 3: Recent reports published in medical education – an overview	47
Is training producing competent, confident doctors?	49
Are curricula consistently aligned to service demands and changing patterns of healthcare?	50

<i>Medical schools need to ensure that graduates are well prepared for clinical practice</i>	50
<i>Foundation doctors need exposure to training across all care settings and in multidisciplinary teams</i>	52
<i>Postgraduate training needs to respond to the needs of health service and workforce requirements</i>	53
<i>Doctors not on formal training programmes need access to training and CPD</i>	55
There are some inconsistencies in the delivery of medical education, which may impact on good medical practice	56
<i>Pressures of service delivery can compromise protected time for education</i>	56
<i>Clinical supervision is variable</i>	58
<i>The learning environment affects medical education</i>	58
<i>Characteristics of individuals can affect experiences and outcomes in medical education</i>	60
Conclusion	62
A note on data	63
Chapter 3: Variations in the standards of medical practice	64
Key information	64
The fitness to practise process stages	65
Triage	65
Stream 2	65
Stream 1	65
Box 4: Overview of the fitness to practise process	66
Standards of medical practice vary	67
The role doctors play in health systems is crucial to good medical practice	68
A small number of UK doctors fall seriously short of expected standards	70
<i>Reporting of complaints is increasing</i>	71
There are common and persistent areas of concern	74
Box 5: Categories of concern	74
Different concerns need different responses	76
There is variation in patients' experiences of medical practice	77
There is variation in practice between groups of doctors	81
<i>We receive and need to follow up on more complaints about male doctors</i>	81
<i>We receive and need to follow up on more complaints about older doctors</i>	82
<i>We need to investigate more complaints about doctors qualifying overseas</i>	83

<i>Ethnicity is not a factor in the number of complaints made or investigated</i>	85
<i>There are differences in numbers of complaints between specialties</i>	87
Conclusion	90
A note on data	91
Chapter 4: Achieving better medical practice	92
A changing profession	93
Professionalism and leadership are crucial to good medical practice	94
<i>Professional guidance must be embedded in everyday practice</i>	95
<i>Revalidation and employers have a key role in supporting good medical practice</i>	96
<i>Good Medical Practice is about more than setting minimum standards</i>	97
Regulatory bodies need to redefine how they work	97
<i>Professional regulation and system regulation must work well together if patients are to be protected</i>	98
<i>We are building stronger relationships with the public</i>	99
Doctors must take responsibility for raising concerns, and need to be supported to do so	99
Overseas qualified doctors need better support	100
<i>All doctors practising in the UK must have adequate English language skills</i>	101
Doctors need to be equipped to deal with the changing healthcare needs of the nation	101
<i>Medical practice needs to meet the healthcare demands of the future and the changing expectations of patients</i>	102
<i>Medical schools' recruitment processes need to be fair and transparent</i>	103
We need to improve our understanding of medical education and data	104
<i>Better information would support medical students and trainees in making career decisions</i>	105
Next steps	105
References	106
Glossary	124
Acknowledgements	140
Notes	141

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. Until recently we have not routinely analysed and shared that information. However, we think it is important that we should do so because it is likely to be of interest to the medical profession, the public and policy makers. This document marks the first and important step in that process.

We collect information mainly as a consequence of carrying out our statutory functions: maintaining the Medical Register; 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: e.g. ethnicity, age and area of practice.

This document sets out much of what the GMC knows about the medical profession and for completeness we have drawn when appropriate on data from other sources. We anticipate that many in the medical profession and beyond will find the information contained within the report of interest and importance. We hope that the demographic data about the medical profession will prove of interest and assistance to those who engage in the important but inexact task of workforce planning.

There is much to celebrate about the state of the medical profession in the UK: the respect and trust bestowed on doctors by the public is unparalleled in any other developed nation. At the same time, there is evidence of unacceptable and largely unexplained variations in the quality of care and we hope that our fitness to practise data will help shed light on relevant factors and the direction of future research. Similarly, while the quality of medical education and training is generally high, there are variances that need to be better understood and explained.

This is the first of what we intend to be annual reports and reflects our commitment to extending our leadership role and being more outward-facing.



Professor Sir Peter Rubin *Chair, GMC*

Executive summary

This is the GMC's first report on the state of medical education and practice. It uses GMC and other data to provide a picture of the medical profession in the UK and to identify some of the challenges that persist. We believe we need to be a more proactive regulator. This report is a step in helping us achieve this. Our aim in publishing this report is to promote discussion and debate on issues and trends that require attention or further analysis.

Key findings

The profession is diverse and changing (chapter 1)

- There is an increasing number and proportion of female doctors.
- Most commonly, doctors are in their early 30s.
- More than a third of registered doctors completed their primary medical qualification outside the UK.
- The medical profession is ethnically diverse compared with the UK's general population.
- The medical specialties in which doctors work vary enormously in size and are not always aligned to service needs.

Medical education plays a key role in supporting good medical practice (chapter 2)

- Medical education and training need to be more responsive to changes in healthcare needs, the organisation and delivery of care, and the shifting expectations of patients.
- There is a tension between service delivery and protected time for education and training, and this has been exacerbated by Working Time Regulations.
- Trainee doctors need high quality supervision and positive role models with strong leadership skills. Yet there is variation in trainees' experiences of supervision.

There is unacceptable variation in the standards of medical practice (chapter 3)

- In 2010 we assessed around 1 in 70 of all registered doctors – although many concerns were subsequently unproven.
- The GMC receives proportionately more complaints about male doctors, older doctors and GPs.
- In 2010 the top three types of concerns were about: clinical investigations or treatment; respect for patients; and communication with patients.
- A small number of doctors are falling seriously short of the standards expected of them. Almost 1 in 3,000 registered doctors were struck off.

Achieving better medical practice (chapter 4)

We have set out six areas for further debate and action.

- 1 Professionalism and leadership are crucial to good medical practice. Revalidation, when introduced, will help by bringing every conversation about a doctor's practice back to the standards set out in *Good Medical Practice*. We have also set up a new team to help employers ensure medical leadership is supported in the workplace.
- 2 Regulatory bodies need to redefine how they work. The GMC needs to proactively encourage good practice as well as take action when problems arise. And professional and system regulators need to work more closely together.
- 3 Doctors must take responsibility for raising concerns and need to be supported to do so. There needs to be a culture change around this. The GMC will do what we can to support this, but there are actions for employers too.
- 4 Overseas qualified doctors need better support. They need to be properly inducted to UK practice and employers need to be confident they can speak and understand English to a good enough standard.
- 5 Doctors need to be equipped to deal with changing healthcare needs. We believe postgraduate training should be reviewed to ensure it is flexible enough to allow doctors to move between specialties. Doctors also need a higher level of core competence than training programmes currently allow.
- 6 We need to improve our understanding of medical education. In particular we need better outcomes data so that we can be assured that medical students are entering the workforce with consistent, and the right, skills and knowledge. In 2013, we will evaluate the impact of our updated standards for undergraduate education, *Tomorrow's Doctors* (2009).

Introduction

Modern technology has improved our ability to collect data on the medical profession, but without effective analysis it is of limited value.

This report begins a process of using and analysing our data to stimulate debate about how we and our partners should work to make sure the profession can be even more effective, and what needs to be done to achieve that.

It uses GMC and other data to provide a picture of the medical profession in the UK.ⁱ

ⁱ Based on data extracted from the GMC database on 31 December 2010.

We hope that the report will contribute to a better understanding of the challenges the profession faces and the wider role it can play in promoting high quality healthcare. We also hope it will help us to reflect on what we have learnt, and enable us to share the data, knowledge and insight we have gathered through our work so we can better protect patients.

We regulate all stages of medical practice, from undergraduate medical education through to retirement from practice. The evidence and the data in this report are necessarily limited and partial, although we have drawn on other sources to provide a fuller picture or greater insight. Together, the data provide a clear view of the changing shape of the profession in the UK, shed light on some of the most serious problems with doctors' practice and reveal how well medical education and training is preparing the next generation of doctors. We hope that by sharing this information and our analysis of it we can open and contribute to debate about the future of medical practice and education in the UK.

Publishing this report annually will allow us, over time, to analyse changes and developments.

The report covers three main themes.

- *A diverse, changing profession* (chapter 1) describes the current composition of the profession, and trends over time.
- *The key role of medical education in supporting good medical practice* (chapter 2) assesses how effectively the current medical education and training system equips doctors to provide a safe, high quality service that responds to society's needs and values.
- *Variations in the standards of medical practice* (chapter 3) looks at what works well currently and where there are concerns about variation in performance.

The final chapter, *Achieving better medical practice* (chapter 4), considers what changes may be required to meet existing and future challenges.

Medical practice is changing

The healthcare needs of the UK's population and the environments in which care is delivered are changing rapidly. The role of doctors is also evolving.

Emerging public health issues highlighted by the UK's Chief Medical Officers' reports,^{1,2,3,4} combined with the rapidly ageing population,⁵ mean that in future doctors will need to focus more of their time on supporting patients with long-term conditions, many with comorbidities.⁶ More doctors will work in the community, and GPs and other practice staff will deliver a much wider range of procedures, as many already are.⁷

Medical practice is also becoming inherently more complex than in previous years.⁸ The greater the knowledge we gain, the more factors doctors have to understand and weigh in the balance when deciding the best course of action for their patients, often under intense time pressures. Ultimately, doctors must take responsibility for their actions.

Patients too have a greater knowledge of health and increasing expectations of their doctors. So the doctor-patient relationship is also shifting and, for many health professionals, including doctors, the emphasis may be 'less on trying to know all the answers and more on knowing how to help the patient find them out'.⁹ Never before have good communication skills been so vital, or involving patients in their own care and treatment so important.¹⁰

Implementation of the Working Time Regulations (WTR), which has recently reduced working hours from 56 to 48 hours a week, has been a further cause of considerable change to the way that doctors work.^{11,12} The WTR have been a positive development in terms of doctors' working conditions and patient safety because fatigue can have a detrimental effect on doctors' performance (discussed further in chapter 2).^{13,14,15} However, in the UK, the reduction in hours has put increased pressure on service rotas, particularly in acute care settings and in some specialties, with possible consequences for how medical training is delivered.¹⁶

The way doctors work has also been transformed by the introduction of multiprofessional teams. This longstanding shift from independent practice to team working demands that all doctors possess and foster team based skills, including working effectively with colleagues and the ability to judge individual performance within a team setting. In many cases, doctors also need to take on more complex leadership roles. Thus, more than ever, doctors are working within systems and their professionalism and ability to adapt to new responsibilities is central to how well those systems perform.¹⁷

At the same time, although health systems across the UK are better funded in real terms than they have ever been, they are also facing demands for unprecedented efficiency savings – £20 billion over the next four years in the NHS in England alone.¹⁸ In Scotland, public services' efficiency savings of 3% (equivalent to around £330m for health) are required this year (2011-12).^{ii, 19} The position for Northern Ireland is similar, with a projected shortfall of about £300 million in health and social care fundingⁱⁱⁱ in 2011/12, potentially rising to £800 million in 2014-15.²⁰ Healthcare costs in Wales have grown by 5% a year for the last five years, and Wales is projected to face a gap of £1.3-£1.9 billion by 2014-15.²¹

The four UK countries are likely to address the need for efficiencies in different ways. This may very well increase the speed at which the healthcare systems across the UK diverge. These differences present challenges for professionals working across these boundaries but also opportunities to deliver care tailored to the needs of the local population.

Issues for the medical profession also need to be considered in the context of our role in Europe, which similarly poses both challenges and opportunities. The European Recognition of Professional Qualifications Directive has made it easier for doctors to move both into and out of the UK. The UK has benefited from this. However, concerns have been raised about whether migration affects the quality of care for both sending and receiving countries given the differences that will exist in the culture, language and health systems between countries (discussed further in chapter 1). This, coupled with expected cuts in public budgets available for healthcare and training in some countries, may further affect the composition of the medical profession in the UK.²²

ⁱⁱ Scotland's next spending review is expected to cover three years.

ⁱⁱⁱ Health and social care in Northern Ireland are integrated, and consequently the estimated funding gap covers both health and social care. It is not possible to disaggregate the shortfall specifically in health funding from this total figure.

The role of professional standards in reducing variation

A host of studies and reports have shown that there are significant differences in the quality of care provided by different healthcare systems across the world.^{23,24} We also know that the UK is no exception both in the context in which medical practice takes place and the outcomes of care.^{25,26,27}

The medical profession is at the heart of the debate about quality and safety and doctors have a key role in improving and maintaining standards of care. The rapid expansion of data about quality, and improvements in measuring the impact of healthcare interventions provide a real opportunity to focus both on patients' experiences and the outcomes of care.²⁸ This information should also enable individual doctors, teams, departments and institutions to monitor their performance more effectively and benchmark themselves against others.

As most practitioners and organisations strive to improve, there are still too many reminders that in some places standards of care and treatment are unacceptably low. High profile examples such as the neglect of older people in England revealed by the Health Service Ombudsman,²⁹ the blatant abuse in care homes such as Winterbourne View,³⁰ and the shocking failures at the Mid Staffordshire NHS Foundation Trust³¹ all raise questions for doctors and

other healthcare professionals about their role in ensuring that every patient has a good standard of care and is treated with respect and dignity.

Such cases raise profound questions for regulators such as the GMC. Our fitness to practise data also provide information on trends in variations in practice. The standards we set for the profession must have a part to play in preventing unwarranted and inappropriate variation in the quality of care and, of course, if they were adhered to appalling practice would either not occur or would be identified and tackled at a much earlier stage.

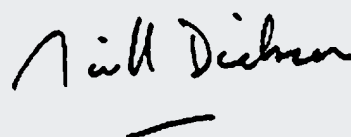
Our core guidance *Good Medical Practice*³² sets out the ethical and legal considerations doctors must take into account in their practice and when making decisions.

We know that virtually every doctor in the UK is aware of the guidance. However, we also know that *Good Medical Practice* is not always playing the part it should both in medical education and clinical practice. In a recent survey, for example, one in 20 doctors reported that they had not referred to the guidance during their medical careers.³³

If we are to help raise standards generally and play a part in addressing serious, system level failings, we need to understand why doctors are not consistently complying with the standards in *Good Medical Practice*, or what may make the standards difficult to put into practice. We also need to know who the UK's doctors are, how well they are being prepared for practice, where there are problems and how we can support them in improving standards and raising concerns about patient safety.

The GMC is one organisation among many aiming to drive up the quality of medical practice in the UK. Although our regulatory responsibility is for doctors only, there is an important relationship between the conduct and practice of doctors, and the wider healthcare systems in which they work; professional regulation is inextricably bound up with system regulation. As such, we work closely with many other organisations, such as healthcare professional regulators, the health system regulators in the UK's four countries, deaneries, the medical royal colleges and medical schools. The Council for Healthcare Regulatory Excellence has a key role in coordinating and joining up the work undertaken across the UK's health regulators.

We are developing and strengthening medical regulation to protect the public and enhance professional development. As we move forward in a number of key areas, such as revalidation (a system whereby all doctors will need to demonstrate their ongoing fitness to practise to the GMC), we must continue to gather insights and data to strengthen this process and continue to guide further developments. We hope that the data and analysis in this report will contribute to that objective.



Niall Dickson

Chief Executive and Registrar, GMC

Chapter 1:

A diverse and changing profession

Key information

Box 1: Facts for 2010

- There were 239,270 doctors on the medical register, of whom 226,682 held a licence. Doctors registered with us across England, Northern Ireland, Scotland and Wales were as follows:
 - England: 178,301
 - Northern Ireland: 6,415
 - Scotland: 19,849
 - Wales: 10,510.
 - Among the registered doctors, 139,381 (58%) were male and 99,889 (42%) female.
 - The average age of registered doctors was 39.9 years, the mode was 33 years.
 - Doctors with a non-UK primary medical qualification (PMQ)** made up 37% of registered doctors.
 - 48% of registered doctors described themselves as white.*** 26% of registered doctors described themselves as Black and Minority Ethnic (BME). However, we did not have ethnicity data on 26% of doctors.****
 - 67,843 doctors were listed on the Specialist Register.
 - 59,738 doctors were listed on the GP Register.
- Other groups of doctors were included on the medical register:
- associate specialists, staff grade and specialty doctors
 - foundation doctors
 - specialty trainees (including GP trainees)
 - doctors who have not been entered onto the Specialist Register.
- * These numbers were based on each doctor's registered address. Other categories include: non-UK; Channel Islands and unspecified.
- ** Gained on completion of undergraduate medical education (ie on graduation from medical school).
- *** White includes white British, white Irish and other white. BME includes Asian or Asian British, Black or Black British, other ethnic groups or mixed ethnic origins.
- **** Of the 26% of doctors we did not have ethnicity data for, 2.6% chose an explicit 'not stated' category.

The medical register and licensing

All doctors wanting to practise medicine in the UK must be registered with the GMC and hold a licence to practise.^{iv}

Registration requires doctors to confirm they understand what is expected of them in the UK, as set out in the professional guidance *Good Medical Practice*. Licensing was introduced in 2009. From this date it was possible for doctors to be on the register without a licence but they are not able to treat patients or practise medicine in the UK.

The total number of registered doctors (including those without a licence) has increased significantly in recent years. In 2010, there were 239,270, compared with 205,829 in 2001 (Box 1).

^{iv} A doctor must be registered with the GMC to work in the UK. The law also requires any doctor who treats patients to hold a licence to practise; only those who are registered with a licence can, for example: work as a doctor in the National Health Service (NHS) or in private practice; write prescriptions and sign death and cremation certificates. Registered doctors who do not have a licence are more likely to be working, for example, as lecturers in a medical school, as managers, or outside the UK

Among those registered and able to practise in the UK there has also been significant growth – up 10% between 2001 and 2010 (Figure 1).

The picture is complicated by the fact that, when licensing was introduced in 2009, the number of doctors able to practise (ie those who chose to take out a licence) actually declined. We do not have hard evidence to explain this, but we believe many of those choosing not to obtain a licence were retired doctors and those working abroad. Some

doctors also gave up their registration altogether. Again we do not have firm evidence, but this may have been related to the fact that, from this date, retired doctors had to pay full registration fees in compliance with the law.

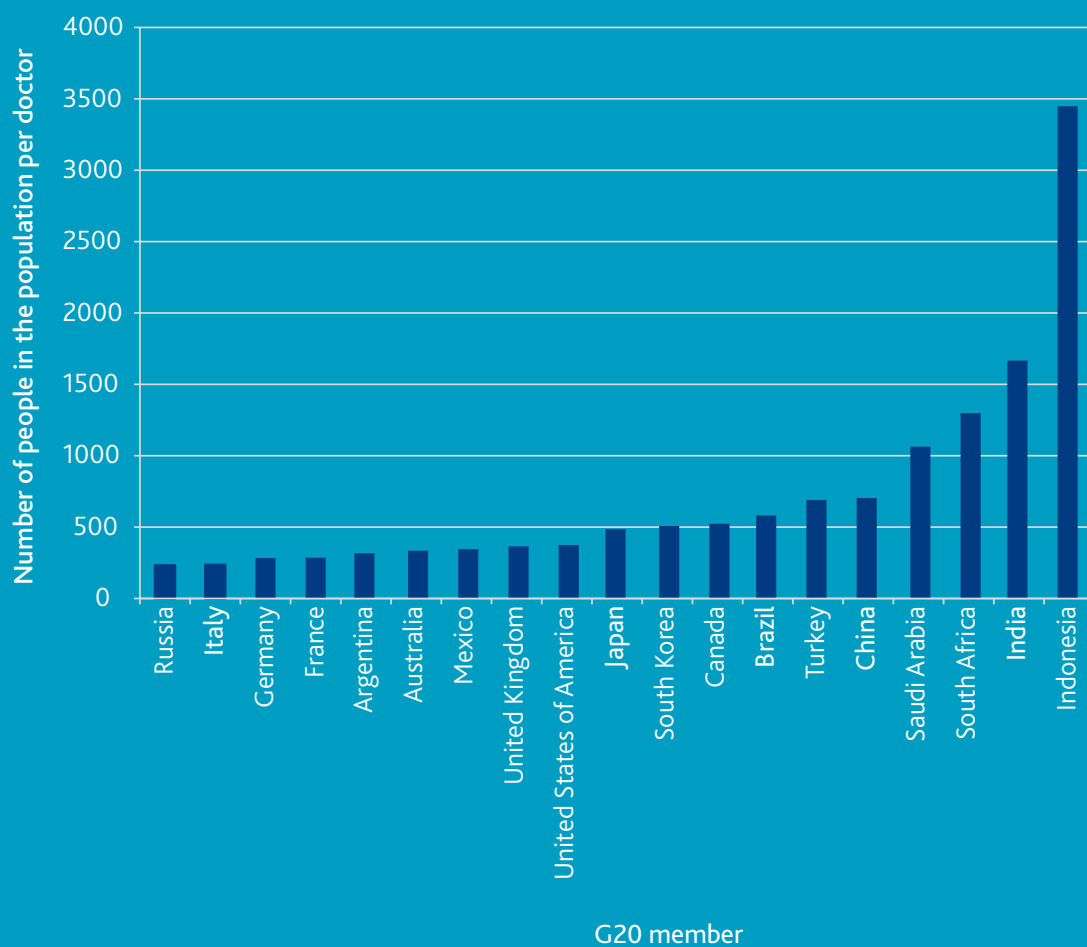
It is difficult to predict the number of doctors in the future as the outcomes of various government policies, workforce planning and public spending reviews may all have an effect.

Figure 1: Number of doctors on the register (2001-10)



The UK has one doctor for every 365 people, similar to the USA, which has one doctor for every 375 of its population.³⁴ Figure 2 shows the number of people per doctor for each of the individual countries in the G20 (made up of the biggest industrialised and developing economies).

Figure 2: Number of people in the population per doctor G20 using the most recent data available for each member



The medical profession is highly diverse and is changing significantly

This chapter describes the current composition of the profession and how it has changed over time, including trends in gender, age, country of PMQ, ethnicity and specialty. We want to have a better understanding of who the UK's doctors are.

Understanding more about the composition of the medical profession is important. If policy makers, employers, the leaders of the profession and the GMC itself are to support clinicians in delivering the best possible care, we all need to understand the backgrounds, expectations and experiences of today's doctors and accept that these will continue to change.

We need to make sure that *Good Medical Practice*³⁵ – a tool that should help to promote consistent, high quality practice – is relevant and meaningful to every doctor in the UK, regardless of their background.

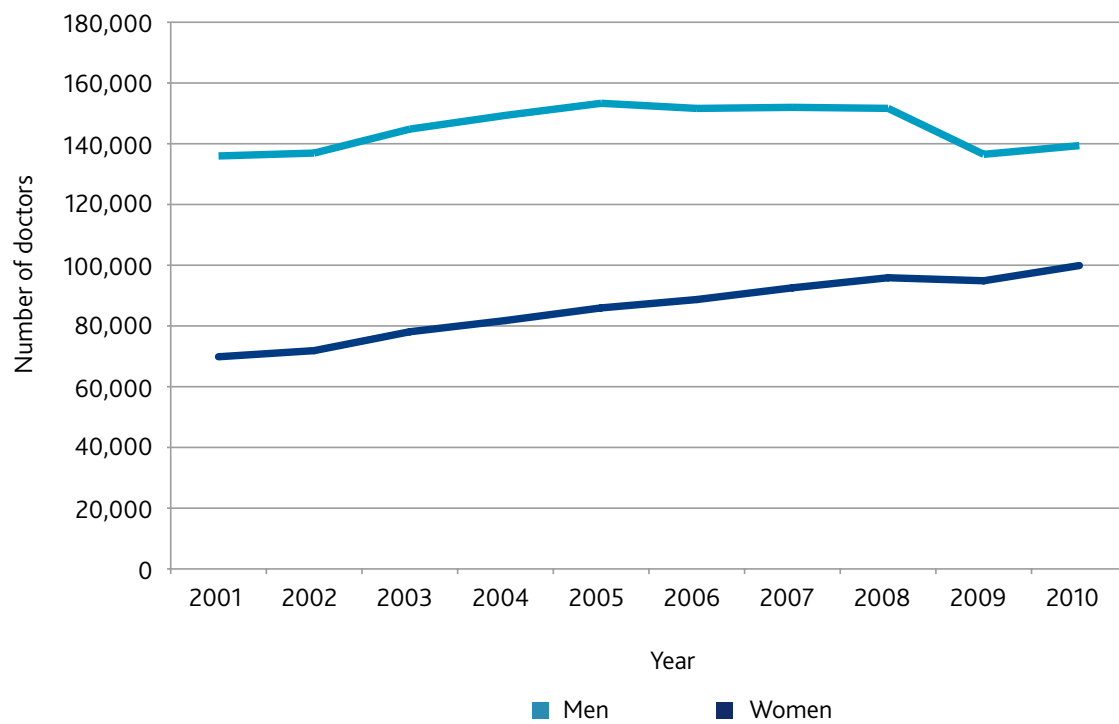
The number of female doctors is set to overtake male doctors

The most significant demographic change in the medical profession over the past ten years has been the growing number of female doctors. Men still outnumber women but, based on current trends, the Royal College of Physicians predicts that women will become the majority of doctors in the National Health Service (NHS) in England at some point between 2017 and 2022.³⁶

This change reflects the fact that the number of women joining medicine has been steadily increasing. In 2001, there were almost twice as many male registered doctors as female. By contrast, by 2010, 58% of doctors on the register were male and 42% were female (Figure 3).

This changing gender balance is particularly pronounced among doctors who qualified in the UK. Here, the number of female doctors has risen by nearly 37% since 2001, while the number of male doctors fell by almost 8%.

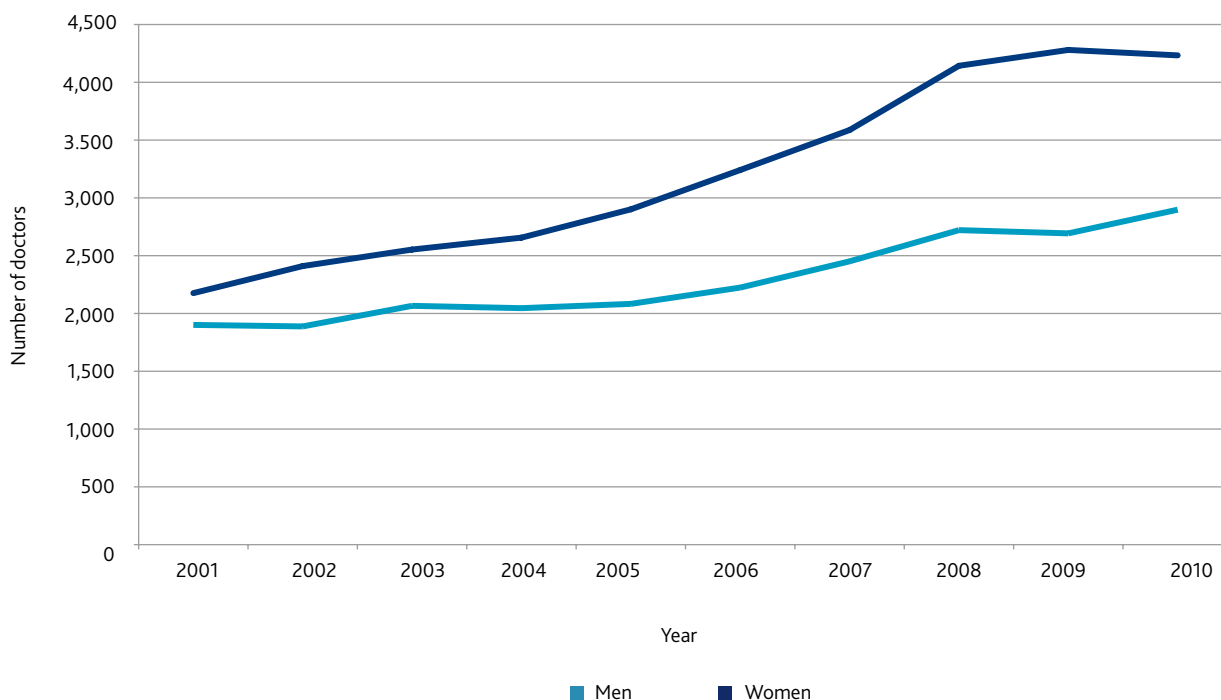
Figure 3: Number of doctors on the register by gender (2001-10)



More women than men have been entering Foundation training in the UK, and the gap has been widening.

In 2010, there were over 46% more provisionally registered (F1) female doctors than male (Figure 4).

Figure 4: Provisionally registered (F1) doctors by gender (2001-2010)^v



^v Data for this ten year timeline are an approximation based on the time of year when the doctor was granted provisional registration.

^{vi} These graphs show the composition of each group of medical students or trainees at a certain point in time. They do not follow through the same group of students from undergraduate to specialty level training, so do not show any comparative trends in gender over the course of a doctor's undergraduate and postgraduate education.

^{vii} The trainee population is defined as all trainees in posts within the GMC approved programmes including academic clinical fellowship (ACF)/clinical lecturer (CL) and Foundation Programmes on the census date: Foundation trainees (F1 and F2); core trainees; higher specialty trainees and GP trainees regardless of their setting; trainees in fixed term specialty training appointment (FTSTA) posts; trainees in locum appointment for training (LAT) posts; and military trainees working in NHS organisations and within the services. These figures do not include out of programme (OOP) trainees.

Figure 5 shows this trend as a 2010 snapshot^{vi} of the three stages of medical education and training: undergraduate, foundation, and specialty (including GP) training.^{vii}

Figure 5: Breakdown by gender at each stage of medical training (2010)

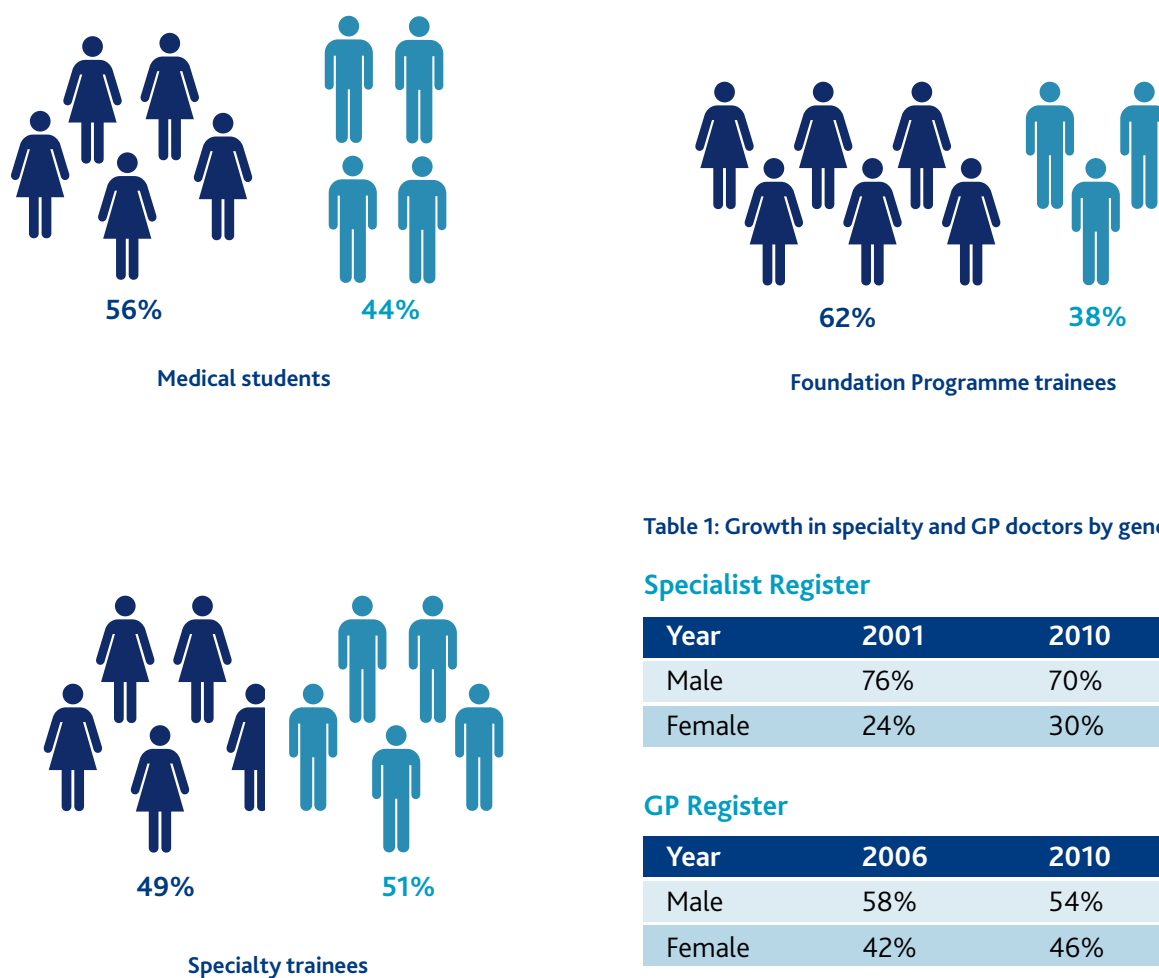


Table 1: Growth in specialty and GP doctors by gender

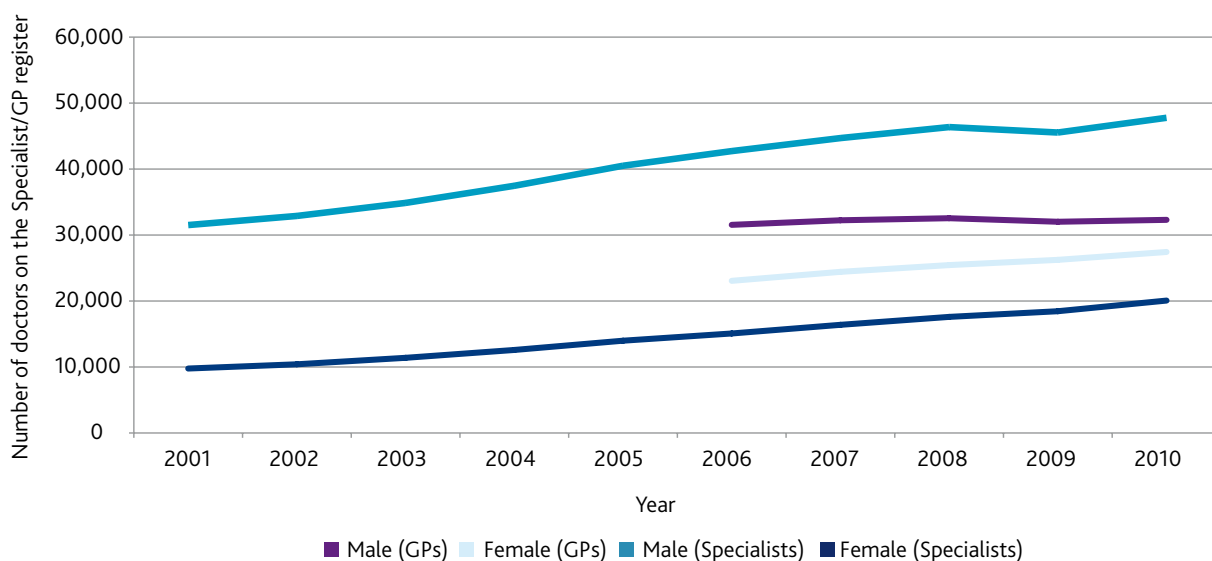
Specialist Register

Year	2001	2010
Male	76%	70%
Female	24%	30%

GP Register

Year	2006	2010
Male	58%	54%
Female	42%	46%

Figure 6: Doctors on the Specialist and GP Register by gender^{viii}



The Specialist and GP Registers show that the number and proportion of women who have completed specialty or GP training routes are also increasing (Figure 6).

Taken together, if these trends persist, medicine will become an increasingly female profession. However, this rate of change may be influenced by trends in the number of doctors coming to work in the UK from abroad. In the past more of these doctors have been men.

Many other developed countries have seen similar trends. In the USA, the proportion of female doctors jumped from 12% to 28% between 1980 and 2006.³⁷ In Norway, 44% of doctors are now women.³⁸ In Canada it is 36%.³⁹ And in New Zealand 40%.⁴⁰

^{viii} The General Practice Register was only established in 2006, hence the difference in the start of the trend line.

Training and workplaces will need to accommodate shifting requirements

The higher number and proportion of female doctors are likely to accelerate some of the already evolving working practices, including requests for part time working or career breaks. Reports such as that of the recent National Working Group on Women in Medicine⁴¹ and the Royal College of Physicians' report *Women and medicine: The future*⁴² point to changes in both the structure of the profession and the support given to women. While these issues are not exclusively female, the speed of change invites questions about the number of doctors needed to be trained, the patterns of that training and how career structures will accommodate the changing nature of the medical workforce. Sir Liam Donaldson, the former Chief Medical Officer for England, has suggested that these changes will require 'a step change in how the medical workforce as a whole behaves'.⁴³

Given changing patterns of work and an ageing population, there is evidence that both men and women are more likely to have caring roles or other responsibilities outside the workplace that need to be accommodated.^{44, 45} The National Working Group on Women in Medicine called for improved access 'to part-time working and flexible training', better childcare and greater support for carers.⁴⁶ It has been suggested that one of the reasons General Practice is an attractive choice for women is that it is easier to work flexibly.⁴⁷ As the landscape changes and the

number of female doctors grows, other specialties may need to adapt to allow more flexible working patterns, which would benefit both men and women. This includes making arrangements for doctors to take career breaks, including maternity or paternity leave, and ensuring that the effect of their absence and subsequent return to practice are carefully managed.

There are also differences in the distribution of male and female doctors across specialties. Women tend to cluster in certain specialties, usually the smaller specialties, as discussed further on p40.

The average age of doctors is falling

In 2010, the average age of registered doctors was 39.9 years, but the overall distribution peaked at approximately 33 years (see Figure 7). This average age looks set to continue to fall if more younger doctors keep entering the workforce.

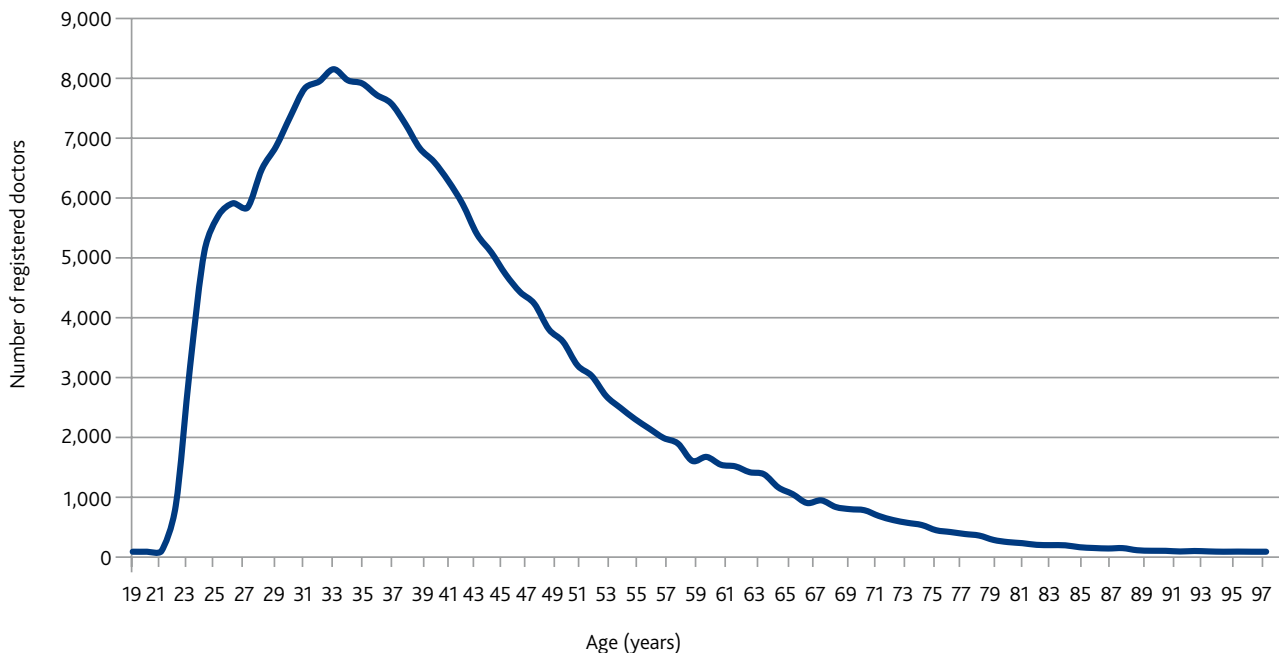
This fall in the average age of doctors is caused by two main factors.

- First, the number of medical students has increased significantly since 1997 as a result of the programme of national expansion of medical schools (NEMS) in England. This programme opened new medical schools and enlarged existing ones with the intention of making the UK self-sufficient in doctors and widening access to medical education.⁴⁸

Secondly, more doctors over the age of 60 have been leaving the medical register since 2009. This followed both the introduction of licensing and the removal of the age exemption on the GMC annual retention fee. Additionally, NHS staff have in the past been able to take voluntary retirement from the age of 50. This may further explain the relatively young average age of the profession (although the voluntary retirement age for the NHS has been raised for newer members of the scheme).^{ix}

The age profiles for men and women are different. Female doctors are younger, with an average age of 36.8 years compared with 42.3 years for men, and there are now more female than male doctors under the age of 32 years (Figure 8). This is consistent with the higher proportion of women graduating from medical school in recent years (see Figure 4 on p20).

Figure 7: Age of doctors on the medical register^x (2010)



^{ix} In April 2010, the minimum pension age was changed to 55 for any member who joined the NHS Pension Scheme for the first time on or after 6 April 2006, or who rejoined on or after 6 April 2006 and had previously left before 1 April 2000.

^x Approximately 15.5% of age data are unspecified.

The changing age demographic has implications for the profession and service delivery

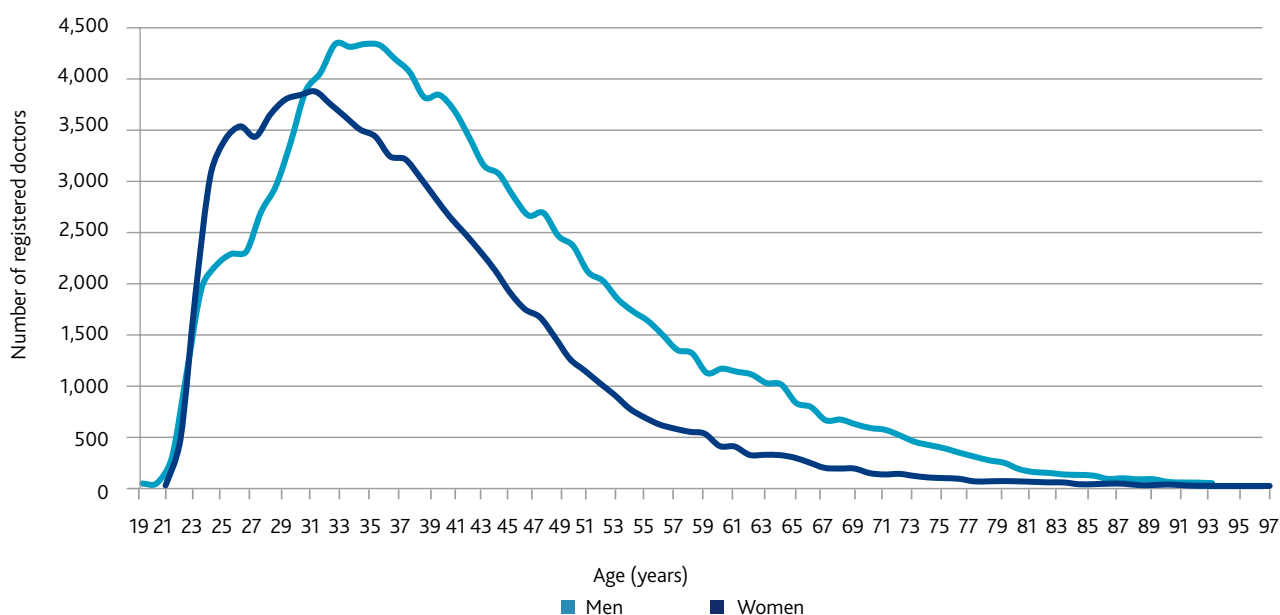
Looking to the future, the projected shift in the age profile of registered doctors raises several workplace and training issues.

A younger doctor profile is likely to affect the balance of inexperienced to experienced doctors, which may have implications both for service delivery and for maintaining enough opportunities for high quality training for all.

Additionally, it may make it harder to fill doctors' posts in rural and remote areas. In the past, new medical graduates have not always regarded working

in rural areas as a positive career option; nor are they 'always encouraged and appropriately trained to work in a rural area'.⁴⁹ A review of the Scottish medical workforce found that recruitment and retention difficulties 'can be most intense in remote and rural areas',⁵⁰ because of issues such as children's schooling, spouse's employment, and contact with relatives elsewhere. Shortages are also apparent in rural Wales.⁵¹ And in Northern Ireland, there have been similar reports around this issue, with the suggestion that, while some trainee doctors do want to work in smaller, rural hospitals to gain a broad range of experience, the majority are more likely to want to work in specialist units.⁵²

Figure 8: Age of doctors on the medical register by gender^{xi} (2010)



^{xi} Approximately 15.5% of age data are unspecified

Career opportunities may also become more limited. As the projected 'bulge' in the number of doctors shown in Figure 7 (see p24) will move through the system, there is likely to be greater competition for senior posts among this cohort.

Moreover, it is possible that a large number of doctors will retire and start drawing their pension at the same time, creating further problems down the line. Of course this could be mitigated by the fact that fixed retirement ages may become less common, the current pension age may change again and more doctors may work in later life.

More than a third of registered doctors qualified outside the UK

All registered doctors must have a primary medical qualification (PMQ), ie an undergraduate (including graduate entry) degree in medicine. The doctors on the UK register fall into three categories:

- those who graduated in the UK
- nationals of the European Economic Area (EEA)^{xii} or Switzerland (and those who are entitled to be treated as such)
- all other doctors, who are classified as International Medical Graduates (IMGs).

Although data on a doctor's country of PMQ does not tell us about a doctor's ethnicity, it does tell us where the doctor completed their undergraduate medical education.

Under European law, doctors who are nationals of the EEA (and those who are entitled to count as such) must be treated the same as doctors who qualified in the UK. This means that the GMC cannot test the competency of these doctors or challenge their PMQ. They must also be given an equal opportunity to compete for jobs and training posts in the UK. European law further restricts the circumstances in which organisations such as the GMC can check the language skills of these doctors. To complicate matters further, current UK law prevents the GMC from imposing any kind of language check on doctors from the EEA. The GMC is working with the UK government to change this. In the meantime, the onus is entirely on employers who should check and assure the clinical competence and English language skills of any doctor they employ, including those from the EEA.

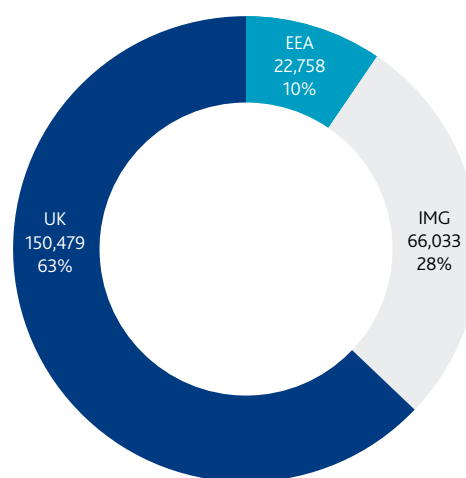
^{xii} The European Economic Area includes all countries of the European Union, plus Iceland, Liechtenstein and Norway.

The proportion of overseas-qualified doctors in the UK has been lower in recent years

Compared with 2001, a greater proportion of UK doctors qualified abroad. However, this proportion peaked in 2005 at just under 40%, and has since been reducing. In 2010, doctors who qualified overseas made up just over a third (37%) of registered doctors in the UK (Figure 9). This decline appears to have been caused by the introduction of work permits for all IMG doctors wanting to work in the UK.⁵³ From 2006, any NHS trust wanting to employ a doctor from outside the EEA had to prove that the post could not be filled by a doctor who qualified in the UK or the EEA. The reduction in the proportion of overseas doctors may have been further encouraged by the introduction of immigration points in 2008.

Historically, IMG doctors have been essential for meeting the shortfall in the number of UK qualified doctors needed to meet NHS demand. However, with more UK graduates coming into the workforce (an explicit aim of the NEMS programme), the demand for those doctors who trained overseas is likely to continue to decline. However, doctors from the EEA are not subject to immigration controls and their numbers are difficult to predict. In 2010 2,960 doctors from the EEA newly registered with us.

Figure 9: Number of registered doctor by primary medical qualification region (2010)



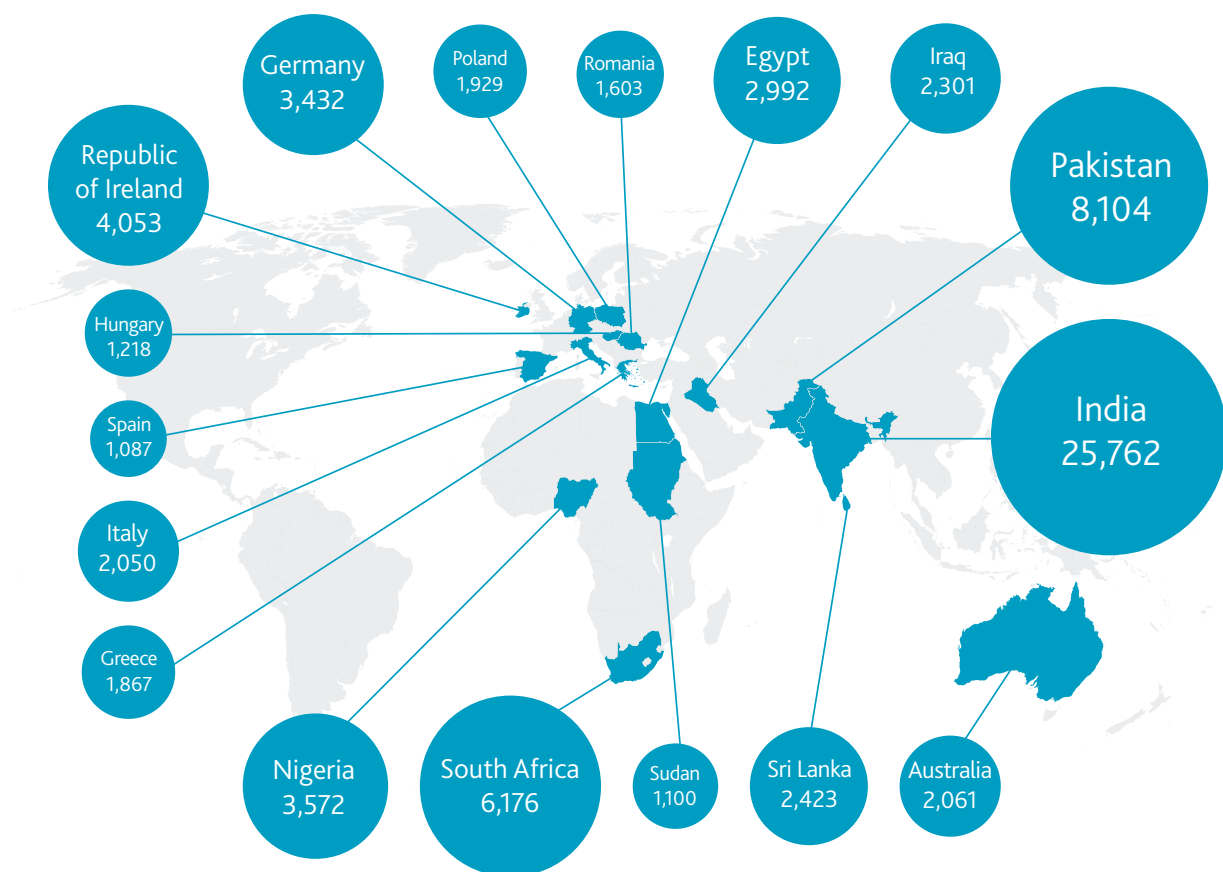
(figures have been rounded up)

Doctors practising in the UK completed their undergraduate medical studies in a wide range of countries

In 2010, around 150 countries were represented on the medical register. After the UK, the country with most doctors on the UK register was India, with

10.8% of registered doctors in the UK, followed by Pakistan, with 3.4% (Figure 10). Only 17 countries each produced more than 1,000 registered doctors with a non-UK PMQ, and more than half the countries represented on the medical register each accounted for fewer than 100 doctors.

Figure 10: Non-UK doctors on the UK register: top 17 countries by PMQ



Doctors who gained their PMQ overseas have a different profile by age and gender

Overseas trained doctors tend to be older than UK doctors, which is hardly surprising as they are likely to have gained some experience in practice before coming to this country. There have also been periods in the past when the NHS was actively recruiting abroad and this will have created larger cohorts of overseas trained doctors who will have made their way through the system.

Overseas trained doctors are also more likely to be men than their UK counterparts (Figure 11), although there has been some narrowing in this trend over the past decade.

Figure 12 compares UK and overseas trained doctors by age. In 2010, the numbers of doctors over the age of 35 who qualified in the UK compared with overseas were roughly equal. Those aged 43-55 years were more likely to have gained their qualification outside the UK. Again, this finding reflects the fact that overseas doctors were recruited at certain times to meet service needs.

Among younger doctors, there are significantly more UK qualified than overseas qualified, again reflecting the recent increase in the number of UK graduates and the fact that overseas doctors are more likely to join the UK register later in their career.

Figure 11: Number of doctors on the register by PMQ region and gender (2010)

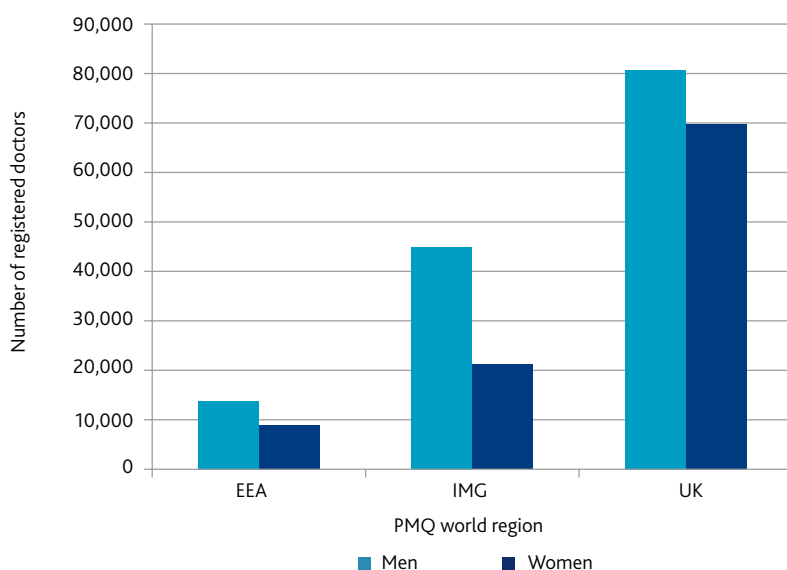
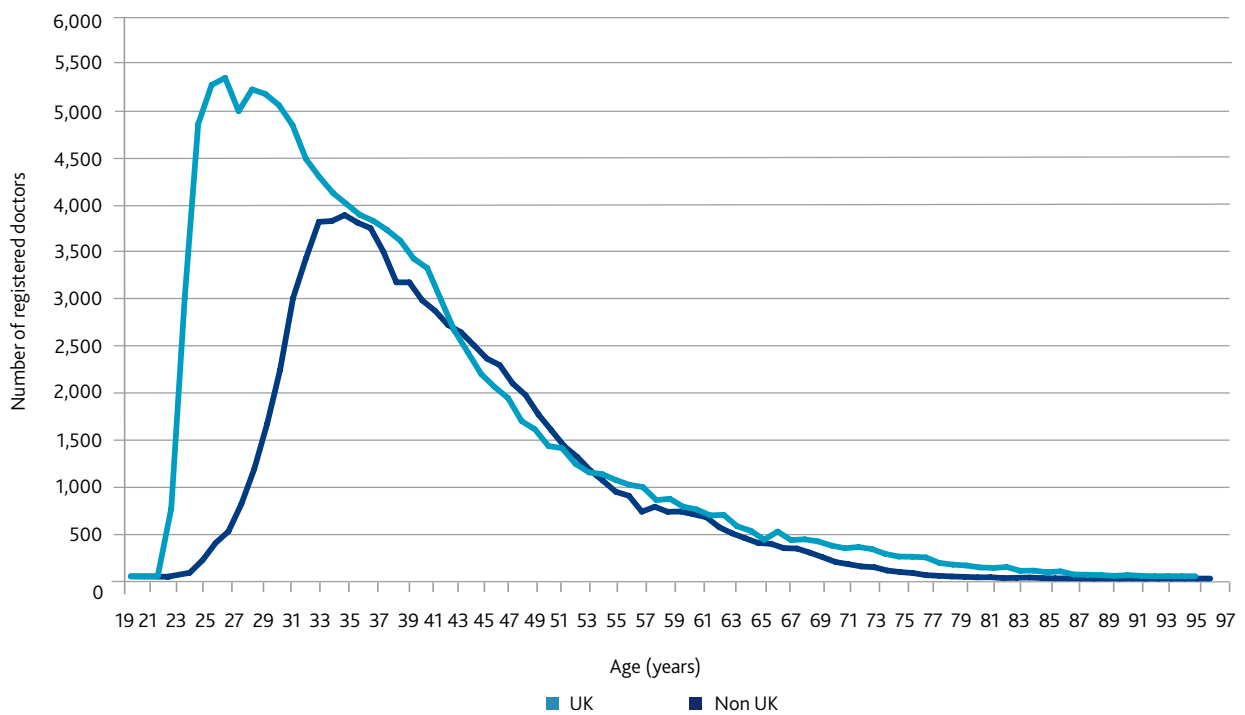


Figure 12: Number of doctors on the register by UK or non-UK PMQ region and age^{xiii} (2010)



^{xiii} Approximately 15.5% of age data are unspecified

There is no doubt that the NHS has relied heavily on the skill and dedication of doctors who were trained overseas – indeed it is evident given the numbers involved that the service could not have been sustained without their contribution.^{54,55} There is in any event a strong argument for having a diverse profession given the increasing diversity of the UK population.

However, doctors who trained abroad can face difficulties when they start to practise in the UK. These include:

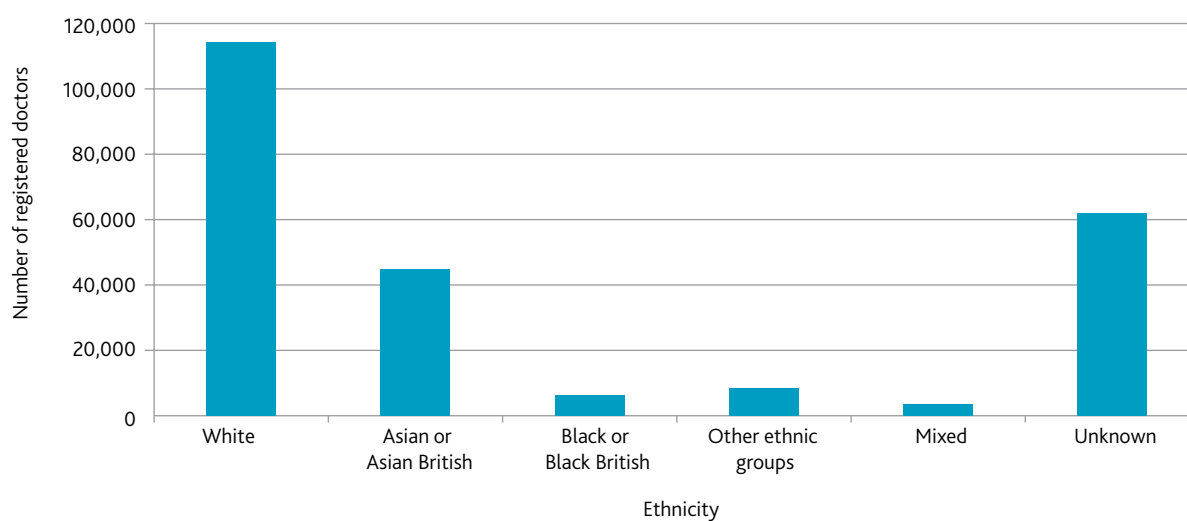
- Unfamiliarity with UK systems (including differences within the UK): doctors trained under different legal, ethical, cultural and professional standards and guidance need information and support, not just about the specific roles they are taking on, but also about the organisation and system in which they will be working. They need to understand how UK medical practice is managed and regulated. Independent research commissioned by the GMC found that many overseas trained doctors experienced ‘a distinct difference in the ethical framework in which healthcare is practised in the UK’ compared with the country where they qualified. This was especially the case in the doctor-patient relationship. However the study also found there was limited opportunity for training for overseas doctors either before registration, or on entering
- the NHS workplace, and what training and support there was placed ‘little emphasis on ethical and professional standards’.⁵⁶
- Communication and cultural differences: many overseas trained doctors in the study mentioned above were concerned about communication on entering practice in the UK. These concerns ranged from ‘difficulties with subtleties of language and dialect to misunderstandings of the nuances of non verbal communication and social and behavioural norms’. Training in communication skills was identified as particularly useful in the induction programmes that had been attended by overseas trained doctors.⁵⁷
- Proficiency in English: IMGs are, by law, required to demonstrate they have the necessary knowledge and skills for registration, which most do by passing the Professional Linguistics Assessment Board (PLAB) test. They are also required, by law, to demonstrate that they have the necessary knowledge of English, which most do by achieving satisfactory scores in the International English Language Testing System (IELTS) test. In 2010, the GMC reviewed the standard required from the IELTS test and, after consultation, increased the score required.

However, as noted above, the GMC is prevented by law from testing the language skills of doctors applying for registration from the EEA. This is an unacceptable gap in current regulation. The vast majority of these doctors would not come to work in the UK if they did not have a good command of English, but there is evidence that a small number lack insight and the language skills required to practise here and thus they pose a risk to patients.

The medical profession is ethnically diverse

Information on the ethnicity of doctors practising in the UK is incomplete because doctors do not have to tell us their ethnicity. At present, we do not know the ethnic background of around a quarter (26%) of registered doctors. This is an improvement from 2001, when nearly 42% of doctors were of unknown ethnicity, but we are committed to improving the quality of the data. Doctors joining the medical register now are asked for more detailed information.

Figure 13 is a snapshot of the information we do have about the ethnicity of registered doctors. In 2010, just under half (47.7%) the doctors on the UK register described themselves as white. Asian or Asian British doctors accounted for 18.7%. A much smaller proportion described themselves as Black or Black British (2.6%), from other ethnic groups (3.6%) or mixed ethnic origin (1.4%).

Figure 13: Number of doctors on the register by ethnicity (2010)

There are similar trends in the profiles of 2010 medical students, Foundation doctors and specialty trainees (Figure 14)^{xiv}, which are based on more complete datasets.

^{xiv} The data in Figure 13 were drawn from the GMC's internal database. The data from Figure 14 were drawn from the student profile returns from medical schools as well as the 2010 national trainee survey.

Figure 14: Breakdown by ethnicity at each stage of medical education

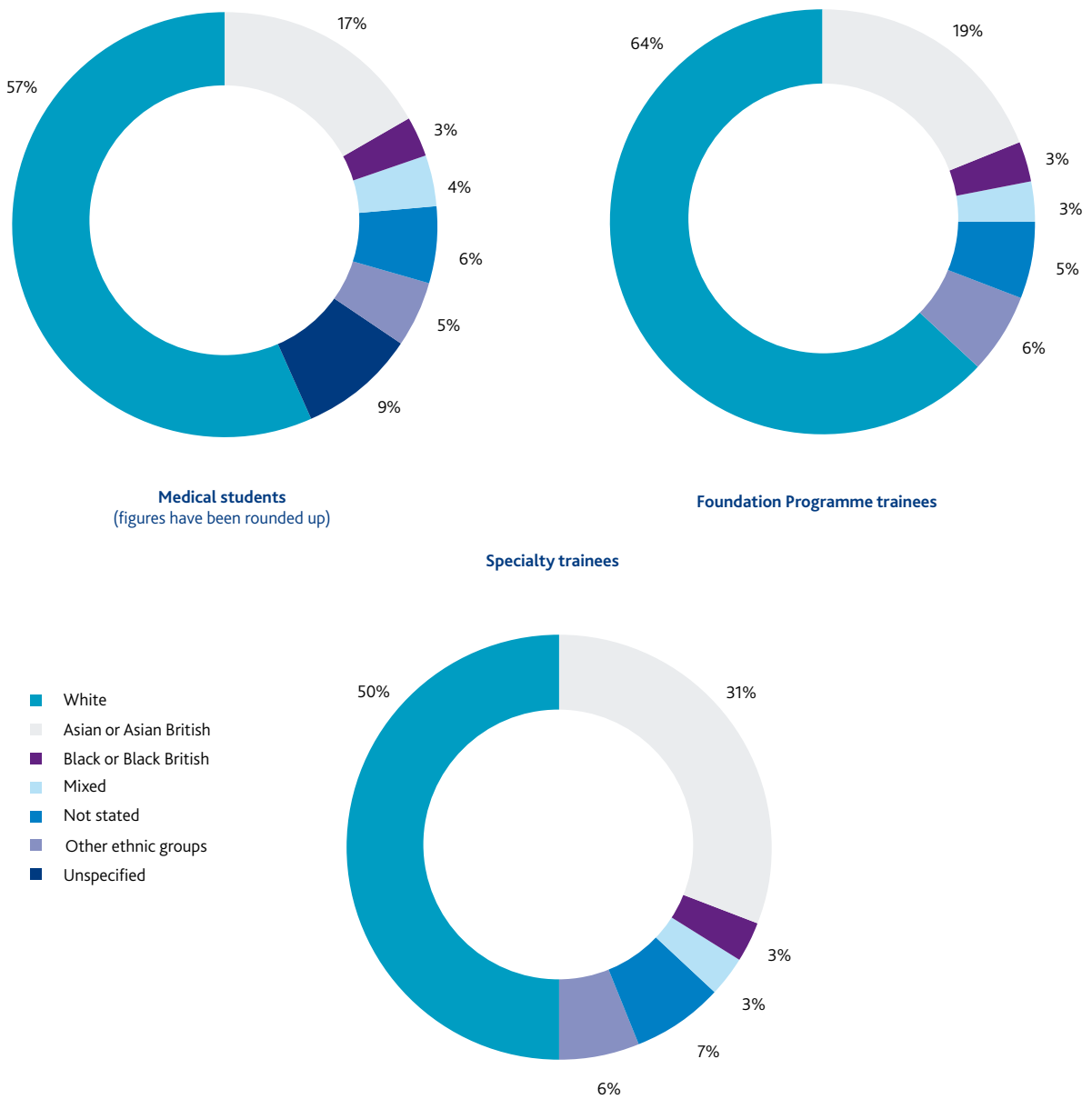
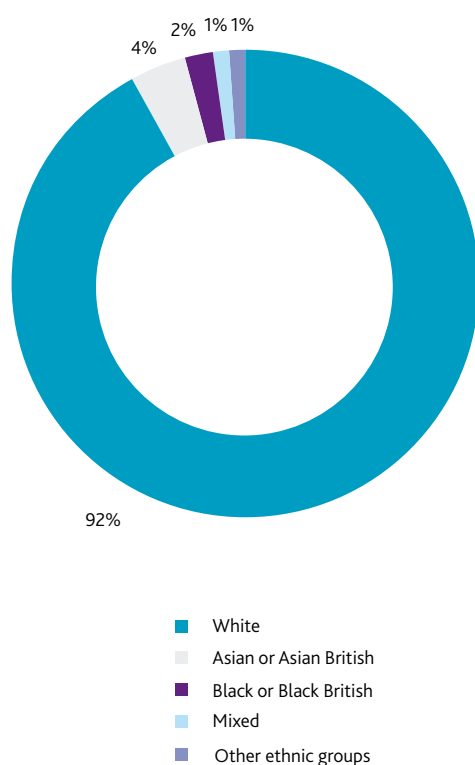


Figure 15: UK population by ethnicity^{xv}

The ethnic profile of medical students (Figure 14) is different from that of the general UK population (Figure 15), with more medical students identifying themselves as Asian or British Asian than in the general population. This trend is also apparent in Foundation doctors, but is even more pronounced among specialty trainees. Overall, the increase in the number of doctors who qualified overseas may have had an impact on the ethnic profile of the registered doctor population. Looking at the data solely for UK qualified doctors, its incompleteness means that it is not possible to reliably identify trends. As we improve the way we collect this information, the quality of the data will improve, and this should provide a better understanding of the ethnic composition of the profession.

Although overall medicine attracts a large proportion of BME students when compared with the general UK population, there are differences in ethnic groups in the numbers that apply and are accepted into university for medical degrees, and the difference is notably marked for Black applicants.⁵⁸ Data provided from University and College Admissions Service (UCAS) information on applications and acceptances to medical schools in 2009 showed that applications from white students made up 45.4% of all applications, but 60.6% of all acceptances. Applications from Asian candidates accounted for 20.4% of all applications and 18.5% of acceptances.

^{xv} The 2001 Census has been used as our source of ethnicity data for the UK population.

In comparison, only 4.8% of applications came from Black students and these applications resulted in just 2.3% of total acceptances. And 3.3% of applications were from candidates of mixed ethnic origin, accounting for 3.6% of all acceptances. (21% of applicants did not disclose their ethnicity.) The BMA report, *Equality and Diversity in UK Medical Schools*, concluded that differences 'could be due to factors including educational differences, social class and direct or indirect discrimination'.⁵⁹

The Chief Medical Officer in England's 2007 report, *Achieving Racial Equality in Medicine*, noted that, while there has been an improvement in ethnic minority representation in the medical workforce, and while the consultant workforce has become more ethnically diverse, it is still predominantly white. By contrast, BME^{xvi} doctors were reported as being the largest sub-group in non-consultant career grade doctors.⁶⁰ More recent medical workforce

census data for England⁶¹ show a continuation of this pattern. BME doctors made up 30.6% of the consultant workforce in 2010^{xvii}, but 56% of associate specialist doctors. Based on the 2010 medical workforce data, of the BME group of consultants, the vast majority were Asian/British Asian, with only 2.7% of all consultants identifying themselves as Black/Black British. Just 6.2% said they were of mixed ethnic origin.^{xviii}

So, while there have been improvements in the diversity of the medical workforce, there is evidence that some BME groups continue to be underrepresented.

Through revalidation, we will be able to collect information on where BME doctors work, and the positions that they hold.

^{xvi} This is a percentage of the total staff whose ethnic category is known. Total BME groups excludes the categories of white and not stated.

^{xvii} As measured on 30 September 2010

^{xviii} From 1 April 2001, newly appointed staff have been asked to classify themselves using the ethnic categories listed in the 2001 population census. Existing staff will be reclassified over time but data returns from 2010 include a mixture of 2001 categories and older information based on 1991 population census categories. The figure of 2.7% for Black or Black British consultants is a total figure representing those respondents that identified themselves as 'Black or Black British' as per the 2001 ethnic group categories, and respondents who identified themselves as 'Black' according to the earlier ethnic group categories.

Doctors work in many different medical specialties, sub-specialties and areas of special interest, each with their own clinical standards

Most doctors working in the UK specialise in an area of practice once they have completed their initial education and training. The GMC currently approves 61 specialties and, within these, 34 approved sub-specialties.^{xix, 62} Our role is to set the standards for training, curricula and assessment systems (including examinations) for these specialties. We also manage the Specialist and GP Registers, on which doctors are listed when they have completed their specialty training. To practise as an NHS consultant or GP, a doctor must be on either the Specialist or GP Register.

The data we hold on specialist doctors and GPs is limited. For example, the Specialist and GP Registers tell us the specialty in which the doctor obtained specialist registration.^{xx} They do not reflect any subsequent change in practice and we know doctors develop their practice and expertise during their careers. For example, evidence gathered in 2005 suggested that 14% of NHS consultants were not working exclusively in the specialty in which they

appeared on the Specialist Register, or in a sub-specialty of that specialty.⁶³

Specialties vary by size and attract disproportionate numbers of trainees

In 2010, there were a total of 67,843^{xxi} registered specialists and 59,738 registered GPs. There were 7,648 doctors in training to be GPs, more than twice as many as any other specialty. This could reflect a policy objective throughout the UK towards more care being provided in the community.

The three specialties after General Practice with the largest number of doctors in 2010 were: Anaesthetics (9,278); General Psychiatry (4,851) and Paediatrics (4,498).^{xxii} Though, when combined, the nine surgical specialties accounted for the largest number as listed on the Specialist Register, with a total of 11,373.

In 2010, there were 31,274 doctors in specialist training (not including General Practice). Those with the largest and smallest number of trainees in 2010 are shown in Table 2. Not surprisingly, those specialties with large numbers of trainees tend to be the bigger ones, although there are exceptions.

^{xix} 288 specialties appear on the Specialist Register. There are several reasons why doctors may be listed for specialties other than the 61 in which the UK currently awards certificate of completion of training (CCTs). When the Specialist Register was introduced in 1997, consultants were registered in the specialty in which they were already practising; some formerly approved specialties are no longer on the approved list; and specialisms of overseas qualified doctors may not align with the UK's approved list.

^{xx} We can only say this for those added to the Specialist Register via the CCT route; we cannot say it for everyone on the Specialist Register or GP Register.

^{xxi} The figures presented in this report to describe the number of registered UK GPs and the number of registered UK (non-GP) specialists includes a small amount of overlap where some doctors are on the Specialist and GP Register. There are 1,289 doctors who fall into this category.

^{xxii} These are the top three (non-GP) specialties as listed on the Specialist Register.

Table 2: Number of specialty trainees (2010)^{xxiii}

Specialties with most trainees		Specialties with fewest trainees	
Anaesthetics	3,765	Intensive Care Medicine	48
Paediatrics	3,097	Psychotherapy	45
Obstetrics and Gynaecology	2,113	Clinical Pharmacology and Therapeutics	43
General Surgery	1,370	Paediatric Cardiology	35
Trauma and Orthopaedic Surgery	1,216	Immunology	35
Clinical Radiology	1,100	Sport and Exercise Medicine	31
Emergency Medicine	958	Clinical Neurophysiology	27
General Psychiatry	949	Nuclear Medicine	21
Geriatric Medicine	697	Audiological Medicine	17
Cardiology	691	Allergy	14

^{xxiii} These numbers are generated from a single snapshot of the total number of trainees in each programme in 2010. Some specialty programmes will be longer than others, and so these will naturally contain a higher number of trainees at any one time. Additionally, specialties with less than ten trainees have been omitted because of very small numbers.

Although General Psychiatry currently ranks as one of the specialties with the largest number of registered specialists and number of trainees, there is evidence that there are not enough psychiatrists to meet service needs. The Royal College of Psychiatry's 2009 workforce census⁶⁴ estimated that 242 psychiatry posts were unfilled across England, Wales and Northern Ireland.^{xxiv, xxv} Data on competition rates for applications to the first round of specialty training in 2010 show a much lower rate for psychiatry (2.8 applications per vacant post) than in the more popular surgical specialties.⁶⁵

The Centre for Workforce Intelligence (CfWI), which is responsible for NHS workforce planning and development in England, has modelled the number of 2011 trainees required in General Psychiatry. The CfWI noted that psychiatry continues to be seen as a relatively unattractive specialty choice for trainees. It concluded that, although there is clear need in psychiatry, historical trends indicate that any new posts would be likely to remain unfilled, and that more work is needed to improve the attractiveness of the specialty to potential applicants.⁶⁶ This under-supply is problematic given that the ageing population is likely to place further demands on psychiatric services, particularly those over 85 for whom comorbidities and dementia are common.⁶⁷

This is just one aspect of how the increasing number of older people means that the balance of specialists in each field will need to reflect the changing needs of patients in the years ahead. Medical practice will have to meet the challenge of treating a population of older patients with chronic disease, many with comorbidities. The Department of Health has predicted that there will be a '252% increase in over 65s with one or more long-term condition by 2050'.⁶⁸

The changing patterns of ill health, and the need to manage this increase in patients with multiple long-term conditions, will put greater pressure on primary care. This poses questions about the appropriate balance between specialists and generalists, and the pros and cons of narrowly defined specialties. The UK has a large number of specialties – 61 approved specialties and 34 approved sub-specialties – compared with many other countries.⁶⁹ In Europe, Sweden comes close with 57 specialties, but the other countries we surveyed ranged between 30 (Norway) and 52 (Germany, Romania and the Republic of Ireland), and most also recognise fewer sub-specialties.^{xxvi} Australia has nearly 80 specialties, but no sub-specialties.⁷⁰ Comparatively, the UK pattern of specialties seems complicated, and may be difficult for patients to understand.

^{xxiv} Scottish data were not included within this census. Also, some large trusts failed to participate in the census, which could mean that the figures presented are an under-estimation of the actual shortage.

^{xxv} The Royal College of Psychiatry's 2010 Workforce Census has not yet been published.

^{xxvi} Data from responses to a questionnaire sent by the GMC to European and international regulators, via the International Association of Medical Regulatory Authorities (IAMRA), using the GMC's European and International Unit.

Men and women make different specialty training choices

As outlined above (on p22), data from the medical register show that the proportion of female (non-GP) specialists increased by 6% between 2001 and 2010. However, it is also clear that women tend to cluster in some specialties and not others. For example, there are a higher proportion of women than men in Palliative Medicine, Family Planning and Reproductive Health, Clinical Genetics and Child and Adolescent Psychiatry. Those specialties with a greater proportion of men (generally the larger specialties) include Anaesthetics, Ophthalmology, Gastroenterology and the surgical specialties.

The gender difference in specialty choices is apparent in other countries. In Australia, the specialties with the highest proportion of female trainees included Obstetrics and Gynaecology (67.9%), Pathology (64.5%) and General Practice (63.8%), while those with low proportion of females included Surgery (23.1%) and Intensive Care (24.3%).⁷¹

Conclusion

The medical profession is diverse and has changed significantly in the past ten years, particularly with respect to gender and age. What is not captured by these figures, however, is that the expectations of the profession as a whole, and of individual doctors, have also changed.⁷²

These changes mean that the profession itself is a huge potential source of variation in practice, especially given the shifts in the different levels of experience, expertise and personal characteristics. In itself variation can be positive, as we can use it to learn and improve standards. So while the profession may be buffeted by change, changes within the make up of the profession described in this chapter may themselves be a driver for positive change.

The needs and expectations of patients are also changing. So too is the system and environment in which healthcare is being delivered.

All of the above combine to pose a real challenge for us as the regulator, and for employers and the profession more generally. We need to ensure that doctors with increasingly different backgrounds, skills and experiences are able to deliver consistently high standards of practice. The profession and the system will need to accommodate these changes in a way

that promotes the delivery of the care that patients need and want. More than this, though, we want to understand and harness positive aspects of variation so we can continue to drive up standards.

The next chapter considers how well medical education and training is equipping doctors from all backgrounds and with varying experiences to develop and maintain the standards of *Good Medical Practice*.

A note on data

Most of the data in this chapter come from the List of Registered Medical Practitioners (the medical register). The register is a unique resource. It provides the only up-to-date, publicly accessible database of all doctors potentially eligible to practise in all four countries of the UK.

Over the past 15 years, there have been improvements in the information we publish on medical professionals. In 1997, the Specialist Register was established 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. Doctors who are eligible are listed on the GP Register, established in 2006. More recently, the introduction of the licence to practise means that the register distinguishes between registered doctors who are allowed to work in the UK and those who are not.

The data are not as comprehensive as we would like. For example, the registers do not provide information on where doctors work or their current area of practice. Some information (such as ethnicity) is incomplete because doctors do not have to tell us. The introduction of revalidation in 2012 will ensure that a far more complete picture of a doctor's practice will be available. The GMC is committed to increasing the amount of relevant information we hold and publish on doctors.

The data in this chapter refer to the register on 31 December 2010 and include provisionally registered doctors. The data were drawn from the GMC's database, Siebel, during April, May, and June 2011. Our quality assurance processes mean that retrospective data fixes will have been made during this period. So there may be slight differences in some of the figures used throughout the report.

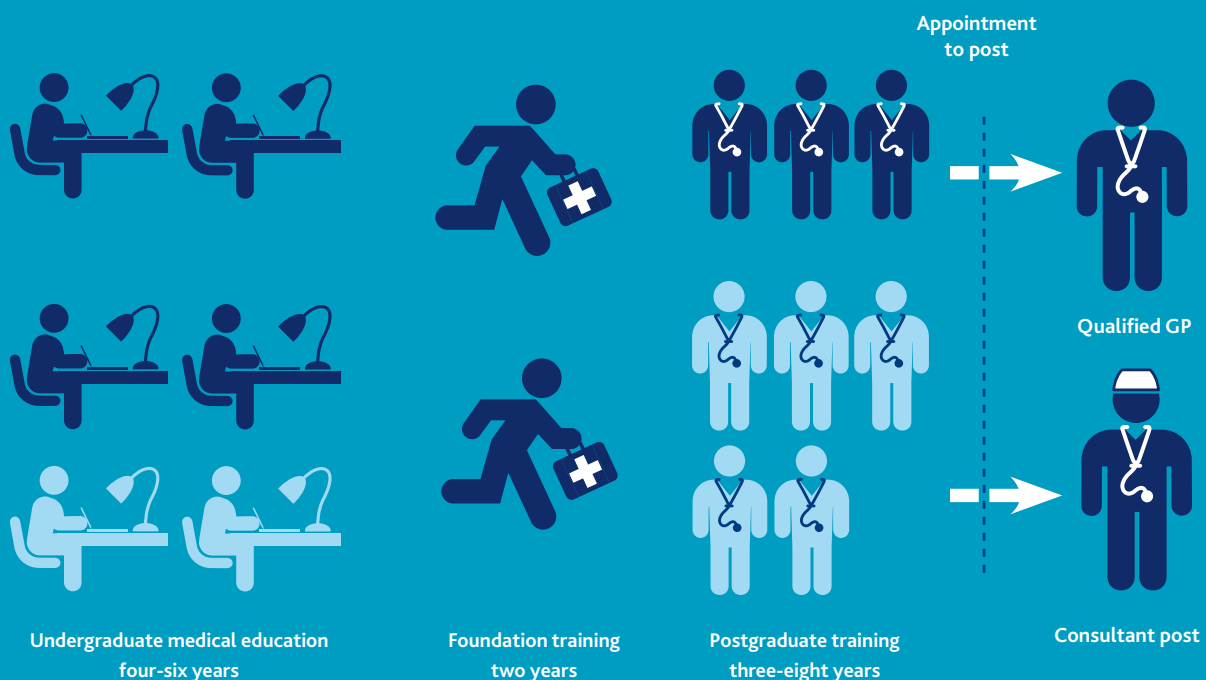
Chapter 2:

The key role of education and training in supporting good medical practice

Key information

There are three main stages of formal medical education and training in the UK.

Figure 16: Stages of medical education in the UK



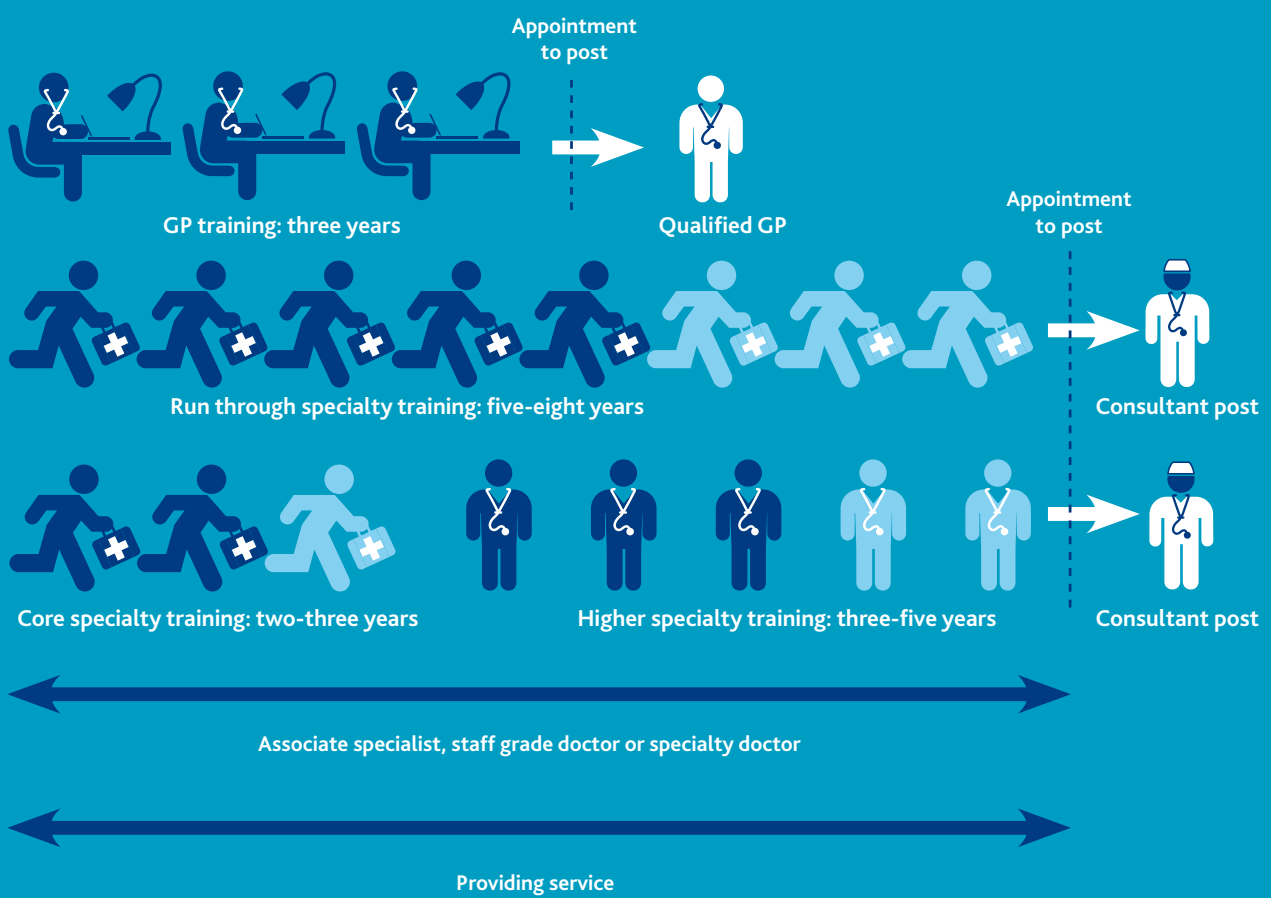
1. Undergraduate medical education: a degree programme providing an academic grounding in medicine and basic clinical skills. There are 32 medical schools in the UK. Undergraduate medical courses in the UK typically last five years; some six-year courses offer students the opportunity also to obtain a related BSc. There are also four-year Graduate Entry Programmes for students with a degree in another subject. In 2010, there were 41,405 medical students across all the years. Those who successfully complete the course are awarded a UK primary medical qualification which enables them to apply for provisional registration with the GMC and entry to the Foundation Programme.
 - Foundation year 1 (F1) builds on the learning, skills and knowledge obtained during undergraduate education. F1 trainees are provisionally registered – those who successfully complete F1 can apply for full registration and a licence to practise medicine with the GMC.
 - Foundation year 2 (F2) focuses on training in the assessment and management of acutely ill patients among other things. F2 trainees are fully registered and licensed.
- In 2010 there were around 14,500 Foundation Programme trainees across F1 and F2.^{xxvii}
3. Postgraduate training: in 2010 there were an estimated 31,300^{xxviii} specialty trainees and 7,600^{xxix} GP trainees in the UK. On completion of specialty or GP training a doctor receives a Certificate of Completion of Training (CCT) or Certificate of Completion of Training for General Practice (CCTGP). This entitles them to apply to register on either the Specialist Register or the GP Register run by the GMC. In order to practise as a GP or a consultant in the NHS a doctor must be on one of these registers. Figure 17 provides an outline of postgraduate medical training in the UK.

^{xxvii} The estimated figure for 2010 Foundation Programme trainees is based on the results of the national trainee survey, which is run by the GMC. The survey yielded a 87.5% response rate of the target population, and so the figures presented here have been scaled up to equal 100% of the target population. However, the target population does not include certain types of doctor. These are detailed in the note on data at the end of this chapter. We recognise the need for improved data collection on the current number of trainees.

^{xxviii} As above, the figures presented here have been scaled up to equal 100% of responses from the 2010 trainee survey target population.

^{xxix} As above, the figures presented here have been scaled up to equal 100% of responses from the 2010 trainee survey target population.

Figure 17: Postgraduate medical training in the UK*

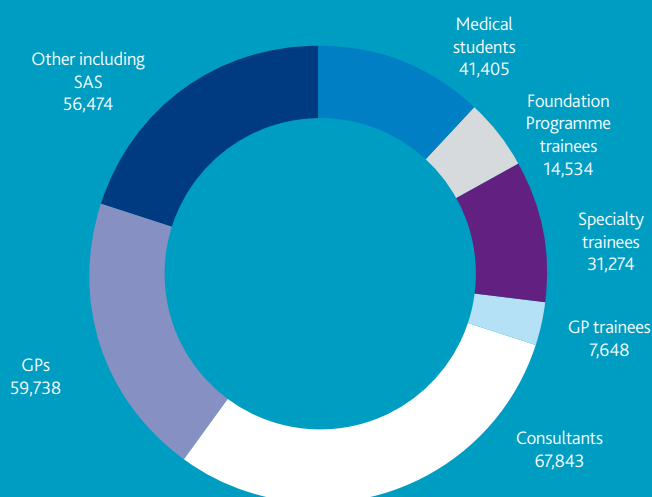


* These timings are indicative so can vary. For example, extensions to training, less than full time training and periods of absence will all extend this.

As outlined in Figure 17, doctors who have not undertaken one of the approved formal training programmes can still qualify for specialist or GP registration. Those who can show that their qualifications or training and experience are equivalent to the standard required for a CCT or CCTGP are eligible for award of a Certificate of Eligibility for Specialist Registration (CESR) or the Certificate of Eligibility for General Practice Registration (CEGPR). These certificates enable doctors to be registered on the Specialist or GP Register. In 2010, there were 3,551 successful CCT applications, compared with 284 applications via CCT equivalent training routes, and 2,310 CCTGP successful applications, compared with 79 successful applications from GP trainees on an equivalent training route.

Also shown in Figure 17, there is a significant number of doctors who do not progress to consultant or General Practice posts. Many work in the NHS as staff and associate specialist (SAS) grade doctors practising under the supervision of consultant or GP. SAS doctors are not part of the formal training programme. We do not know from the medical register the number of doctors working in these types of post, although one recent estimate has put the figure at up to 20,000.⁷³ Figure 18 below shows the make up of the medical profession in 2010.

Figure 18 Make up of the UK medical profession (2010 snapshot)^{xxx}



^{xxx} The data here are drawn from several sources (see 'A note on data', p63). The diagram represents a snapshot of all doctors in medical education and practice at the end of 2010. As such, some categories, such as longer training courses, will naturally contain higher numbers. Furthermore, Foundation Programme trainees include those students who are enrolled on the Foundation Programme and have not yet entered specialist or GP training.

Box 2: The GMC's role in medical education and training

Across the UK, the GMC is now responsible for setting standards and monitoring every stage of medical education and training as well as overseeing continuing professional development (CPD). We took on responsibility for postgraduate education in April 2010.

We have various ways of making sure that education and training is of a high quality – these are set out in our 2011 *Quality Improvement Framework*.⁷⁴ The outline of our approach is set out below.

Undergraduate education

- While we do not have a role in the selection of individual medical students, we set standards and outcomes for undergraduate medical education in the UK which are contained in *Tomorrow's Doctors* (2009).⁷⁵
- We run a quality assurance programme⁷⁶ which assesses how effectively medical schools meet the standards in *Tomorrow's Doctors*.⁷⁷
- Medical schools select their own students and set their own curricula but they must comply with GMC standards and achieve the outcomes we set.
- Schools are inspected on a regular basis and are required to submit an annual return showing how they are meeting the standards required.

Postgraduate education

- We approve the curricula and assessment systems for foundation training, specialty including GP training and sub-specialty training.
- We also approve both individual postgraduate programmes (for example, a local programme in Paediatrics) and the posts in NHS and non-NHS healthcare providers, in which trainees complete these programmes.
- We set standards for the Foundation Programme and for specialty and GP training – these are contained in *The Trainee Doctor*.⁷⁸ Postgraduate deaneries are accountable to us for managing the quality of this training.
- We analyse and monitor the quality of education and training based on information including: reports from deaneries and medical royal colleges, annual surveys of trainees, concerns raised by trainees and a programme of inspections of deaneries and local organisations which provide training.
- We work with the other public bodies across the four UK countries involved in medical education and training, including NHS Education for Scotland (NES), Medical Education England (MEE), the Postgraduate Deanery in Wales and the Northern Ireland Medical and Dental Training Agency (NIMDTA).

Good medical education is essential to good medical practice

It prepares tomorrow's doctors for practice, and ensures, through lifelong learning, that doctors continue to meet the standards of *Good Medical Practice* throughout their careers.

Consistent training standards for doctors are important to protect patients because trainee doctors provide a large proportion of NHS medical care, a fact that is poorly understood by the general public. Standards are also vital because trainee doctors move between specialties, institutions, and in some cases between different parts of the UK.

Medical education is being delivered in a changing environment

There have been significant developments in UK medical education and training in recent years. The most significant of these was the launch of Modernising Medical Careers (MMC) in 2003 which reformed the structure and content of postgraduate specialist training across the UK.

Further change has been advocated in several key areas, both to complete the process of reform and to reflect ongoing change in the external environment. This in turn has led to the publication of a number of seminal reports pointing to the need for further improvement (Box 3).

Box 3: Recent reports published in medical education – an overview

- Sir John Tooke's report *Aspiring to Excellence*⁷⁹ (2008) examined the implementation of Modernising Medical Careers.
- Professor Sir John Temple's report *Time for Training* (2010)⁸⁰ looked at the impact of the European Working Time Directive (EWTD) on medical training and education.
- Professor John Collins's report, *Foundation for Excellence* (2010)⁸¹ reviewed the Foundation Programme in England.
- Dr Alistair Cook led a review of the Scottish Foundation Programme (2010).⁸²
- Lord Naren Patel led a review into the regulation of medical education and training.⁸³

Some of these have already produced change including Sir John Tooke's recommendation that the Postgraduate Medical Education and Training Board (PMETB) should be merged with the GMC. Others such as the review of the EWTD have stimulated further research and debate. And more change is on the horizon.

In 2010, the Department of Health in England consulted on the future of healthcare education⁸⁴ including medical education. This included plans to establish Health Education England (HEE), which will have responsibility for overseeing the commissioning of professional education throughout England.

This multidisciplinary oversight of education is a positive development and we welcome the opportunity to work with HEE to raise standards. The future role of postgraduate deaneries has been less apparent in the Government's plans, and we are pleased that this is now becoming clearer. Postgraduate deaneries have a critical quality management function. They also ensure effective recruitment, rotation and progression of trainees and provide support for trainees outside the workplace. They help to manage the relationship between training and service and, as a result, continuity of care for patients.

Additionally, postgraduate deans, as designated Responsible Officers for doctors in training, will have a key role in revalidation.

Irrespective of the structures that will be put in place in England or the rest of the UK – it is not for the GMC to determine those structures – our commitment to raising standards in medical education and training will continue.

Tuition fees are also changing in England and will potentially leave every medical graduate embarking on their career with more than £45,000 of debt. Although provisions have been made for students from low income families,⁸⁵ there is concern that this could deter applicants from poorer backgrounds from applying for long courses such as medicine.⁸⁶

There have also been concerns that the added cost of a further year will reduce the number of medical students who choose to study in an additional subject in order to gain a BSc as well as a medical degree. This may in turn affect recruitment to Academic Medicine as candidates may have less experience of research.

Wider resource constraints and the need for health systems to find efficiency savings may also have a damaging impact on the training of doctors throughout their careers. We need to ensure that training is properly funded, and that it is clear what money is being spent for what outcomes. Training is expensive and, at a time when money is tight, it is more important than ever that that expenditure can be accounted for and protected. Funding for education and training should be transparent, follow the trainee, and set against robust and agreed measures of quality, which link directly to the standards set and data required.

Is training producing competent, confident doctors?

In the 2010 national survey of trainees, nearly 90% of those approaching the end of their training were confident about taking up a new role as a consultant or GP.⁸⁷ Research into applications for certification commissioned in 2008 by PMETB reported similar findings. 98% of successful applicants for certification who responded to the survey stated that they felt qualified and had sufficient experience to take up a substantive consultant or GP post at the point of certification. The survey also showed positive findings about successful applicants' subsequent employment.^{xxxj, 88}

- 88% of successful applicants followed the expected career pathways, with either consultant/locum consultant posts or GP posts.
- Just over 91% either remained in, or moved to, the UK after certification.
- 78% of successful applicants based in the UK after certification and working as GPs and consultants took less than six months to find their jobs. (Although other considerations will have affected reported applicant success, for example, availability of relevant consultant posts, candidates' preferred geography etc.)

However, even if most doctors produced by the system practise safely and well, some do not and, as chapter 3 on clinical practice will show, standards

vary significantly and there is still much to be done to address this. The maintenance of high standards within medical education and the drive for greater consistency within and between specialties will help. At the same time, medical education needs to keep pace with shifting patterns in the organisation and delivery of care, and in patients' expectations.

It is also critically important to ensure that prospective medical students and would-be trainees understand the commitment they will need to make at each stage of their careers, and that they either have, or have the potential to develop, the qualities that will be required to practise as a doctor.

The point of entry to medicine is the medical schools' selection processes. These should be fair and evidence based. There is evidence that lower socio-economic groups are under-represented in the medical profession.⁸⁹ Universities are undertaking work to support under-represented groups. This should be encouraged and extended, and best practice shared across the sector. There is also evidence that medicine attracts a lower proportion of disabled students than is found in the general university population. This may reflect the particular challenges of practising as a doctor or an unwillingness of applicants to disclose information on disability.⁹⁰ The *Gateways* guidance provides practical advice to medical schools to ensure that disabled students do not face unnecessary barriers in their undergraduate education.

^{xxxj}This included trainees on the CCT route and those on the equivalent training routes.

Are curricula consistently aligned to service demands and changing patterns of healthcare?

Medical schools, postgraduate deaneries and medical royal colleges and faculties are well aware of the need to match the content and standards of training programmes to the demands of the health service. However, there is evidence that further improvements could be made to make sure that curricula are more responsive to changing patterns of healthcare.

Medical schools need to ensure that graduates are well prepared for clinical practice

In our quality assurance visits (inspections) of medical schools (2005-10), we found inconsistencies and variation in the assessment policies and practices. This raises the question of whether all graduates have the same minimum standards of clinical competence.⁹¹

There is evidence that, in the past, some medical graduates reported being unprepared for some of the practical skills required of them when they entered Foundation training.^{92, 93, 94, 95, 96, 97}

Of course recognising the limits of one's own competence is a necessary and positive attribute for any doctor and it may be that the feeling of being unprepared could have more to do with a lack of self-confidence than with the quality of undergraduate medical education. Given the huge knowledge base of clinical practice, being fully prepared is impossible.

However, we do need to understand whether some aspects of practice are not covered well enough by existing curricula, whether students are being given enough exposure to clinical environments and 'hands-on' practical skills, and whether newly qualified doctors are being asked to undertake tasks that are inappropriate for their level of experience. Medical schools also need to understand, through feedback from their graduates, whether there are any elements of their education and training that could be improved. We also need to consider the role of technology enhanced learning. It is increasingly unacceptable for medical students and trainees to practise skills and procedures on patients without prior simulated experience.

In 2008 and 2009, we commissioned two pieces of research to look at how well prepared medical graduates are for practice.^{98, 99} The first research study¹⁰⁰ showed that, while most doctors sampled felt ready for basic tasks (such as taking a patient's medical history), some expressed concerns about the practical procedures required of them.¹⁰¹ Other research we commissioned¹⁰² also produced evidence of Foundation doctors' prescribing errors.¹⁰³ The research concluded that preparedness would be improved by more learning 'on the job' within clinical practice, including improved and better supervised clinical placements, and an opportunity for students to take on greater responsibility within medical teams. In response, the revised 2009 version of *Tomorrow's Doctors* requires a more structured approach to the content of undergraduate clinical placements. This leads to a period of 'student

assistantship' during which a student acts as assistant to a trainee doctor, with defined duties under appropriate supervision. We have published a series of supplementary advisory documents, including on clinical placements and student assistantships, as guidance for medical schools on how best to implement the new requirements. Medical schools have adjusted their programmes to introduce clinical assistantships.

The Medical Schools Council is also undertaking work to share common assessment materials across all UK medical schools. Additionally it is exploring how information can be better shared between medical schools and postgraduate deaneries, and across organisations where medical students undertake clinical placements.

Different approaches and curricula across medical schools mean that there will inevitably be some degree of variation in outputs across medical schools. The revised 2009 *Tomorrow's Doctors* is only now being implemented, and it is too soon to judge its impact on the content of undergraduate clinical placements. But we will continue to monitor how far, and how effectively, the new standards are being adopted, whether we are achieving the right balance between education and training, and whether we can be confident of equal standards at all medical schools.

We know from research we commissioned that Foundation doctors feel particularly under-prepared in terms of their prescribing skills,^{104,105} and so we will continue to work with the Medical Schools Council and the British Pharmacological Society as they consider approaches for developing a standardised Prescribing Skills Assessment. We will also continue to engage in discussions with the Medical Schools Council about including shared questions in all medical students' final examinations as a means of measuring variations in performance across the UK's medical schools.

The GMC has previously considered the arguments for and against introducing a national licensing exam. National exams are in place in some other countries including the USA and can demonstrate that minimum standards are consistently achieved across universities.

However, there are also risks. These include restricting local innovation and placing too great an emphasis on skills that can be tested in an exam at the cost of equally important skills that cannot. Alternative approaches, such as some common questions in all final exams, may achieve similar benefits.

We will review and further consider these arguments when we come to assess the impact of *Tomorrow's Doctors* (2009) and the Medical School Council's project on assessment (described above).

Foundation doctors need exposure to training across all care settings and in multidisciplinary teams

Foundation doctors learn primarily in supervised clinical environments. In the UK, there has been a strong policy drive for many years to shift the delivery of healthcare, where clinically appropriate, into primary and community healthcare settings.¹⁰⁶ This trend, which admittedly has been slow to realise, does look set to continue. The major demand on healthcare over the next 20 years will be the ageing population and with it increasing prevalence of long-term conditions and multiple pathologies and a need for high quality end of life care. There will remain a huge demand for elective and acute care in hospital settings, but it will be essential that the education of doctors keeps pace with the shifts in healthcare design and delivery and creates doctors who can work flexibly in new environments.

The 2010 evaluation by Professor John Collins of the Foundation Programme in England, *Foundation for Excellence*, identified a number of shortcomings in this area and concluded that the current Foundation curriculum was not sufficiently aligned to the changing needs of the NHS.¹⁰⁷

- Although the focus of the Foundation Programme was correctly on acute illness, there were gaps in the training for managing long-term conditions and in treating the 'total patient'.
- Acute hospitals were not necessarily the best places to provide trainees with experience of managing long-term conditions, and training should encompass community settings where

much of this care is now provided. Dr Alistair Cook's review of the Foundation Programme in Scotland similarly reported that Foundation doctors could benefit from more community and general practice placements.¹⁰⁸

- Training should include the experience of working within multidisciplinary teams, so as to reflect emerging practice.

Data from the 2010 trainee survey suggest a lack of team based learning – just over half reported that they had never learnt alongside other professions.¹⁰⁹

Collins noted that in England 'the distribution of [Foundation trainee] placements by specialty does not reflect the current and future needs of the NHS'.¹¹⁰ A large proportion of placements are in adult medicine and surgery which, although clearly important, should not be allowed to detract from the need for trainees to gain wider experience across a range of specialties – for example, also spending time in Paediatrics, General Practice and General Psychiatry, so as to ensure 'broad based beginnings', a core principle of MMC.¹¹¹

We support the inclusion of primary care and community experience in Foundation doctors' training, and will continue to work with postgraduate deaneries in its development. If they are properly organised, these settings can provide Foundation doctors with experience of different types of patients with a wide mix of medical conditions. The Academy of Medical Royal Colleges' Foundation Committee is completing its review of the Foundation Programme curriculum, which seeks to address Collins' recommendations.

The first contact with patients as a qualified doctor will always be an anxious time for new graduates, and it is critical that Foundation doctors are given adequate support in making the transition from medical school into Foundation training. Properly equipping Foundation doctors is not just about ensuring that they possess the right technical skills. Foundation doctors also need exposure to learning in multidisciplinary teams, and across all of the settings in which healthcare is delivered. Increasingly this will include primary and community care settings, and the curriculum of the Foundation Programme needs to develop in response. We welcome the work that the Academy of Medical Royal Colleges' Foundation Committee is undertaking in this area. And, recognising that the Foundation Programme needs to better respond to changing healthcare needs, we will actively monitor this issue by seeking feedback from patients, trainers and employers so we can continue to understand how curricula may need to change in the future.

Postgraduate training needs to respond to the needs of health service and workforce requirements

Both Sir John Tooke¹¹² and Sir John Temple¹¹³ highlighted the need to align workforce planning more closely with what patients need in their reports. The Tooke inquiry found that specialty training structures and opportunities were not consistent with the need for more community care,¹¹⁴ as Professor John Collins noted in his later evaluation of the Foundation Training Programme in England.

The number and distribution of specialty posts should be determined by the future needs of the health service. There is important work underway

to ensure we have adequate training opportunities to meet service needs in the future. The CfWI in England and NHS Education for Scotland (NES) have made recommendations for the next four years covering specialties and geography. In England, this could mean an increase in the number of GP training opportunities and a decrease in the opportunities to train in hospital based specialties.¹¹⁵

Workforce planning is of course inherently complex. And given the length of training and the unpredictability of demand it will always prove to be an inexact science. What is important, though, is ensuring that the system can respond to shifting demand and emerging priorities in healthcare need. There is an ongoing discussion about whether the structure of training should allow greater flexibility for trainees to transfer between specialties, for example, if trainees find that they are better suited to another specialty or where workforce requirements change. The current architecture for training does not easily allow for this. Sir John Tooke noted the difficulty presented by 'run-through' training and argued that this model did not provide the flexibility required as health needs evolved.¹¹⁶

As Professor John Collins pointed out there is also a need for trainees to balance their ambitions with realistic expectations of those specialties which continue to be over-subscribed.¹¹⁷ The number and distribution of specialty posts, whether for trainees or consultants and GPs, should always be dictated by what patients need. However, in future there may well be a mismatch between doctors' preferences, the pool of suitable candidates, the opportunities available and what the system requires.

Already many training specialties are heavily over-subscribed, meaning there is greater competition for training posts, particularly in surgical specialties. For example, in England the NHS is urging trainee doctors to consider both the competition for training posts and the future shape of healthcare in choosing their specialty. The expectation is that the nature of medical practice will change as more care is delivered in the community. It is not clear that all young doctors have taken on board the fact that around half of the medical specialty training posts in England in the next few years 'will be in General Practice, whereas the number of posts in surgical specialties is decreasing', according to the Department of Health in England.¹¹⁸ UK competition rates for applications to GP training in the first round of 2010 stood at an average ratio of 1.7 applicants per vacant post, far lower than for other specialties.¹¹⁹ We know there are shortages of suitable applicants for training opportunities in other areas, notably psychiatry.

Medical students and trainees need better information to make their career choices, including information on competition rates and the likelihood of success in one's preferred career choice. For example, the CfWI's *Recommendations for Specialty Training 2011* showed a mismatch between the number of core surgical trainees and the availability of higher specialty surgical training posts. In 2010

there were 621 core surgical training posts, but in the same year only 288 higher specialty training posts. Based on CfWI modelling, the likelihood of progressing to higher specialty training from core surgical training is currently about 36%.¹²⁰ Medical students, Foundation doctors and trainees need to understand competition rates and strongly consider their chances of success so they are better supported to make informed, pragmatic decisions about the areas of practice in which they choose to train.

Another area of potential concern is over-subscription to the Foundation Programme. In 2010-11 there were three times as many applications from overseas qualified medical graduates than in 2009-10, creating for the first time a surplus of demand for places.^{xxxii} There were 7,257 eligible applications^{xxxiii} for 7,073 places.¹²¹ As a result, 184 applicants were placed on a reserve list. In previous years the Foundation Programme has been under subscribed.¹²²

It is difficult to estimate the number of students who will withdraw after being successfully allocated a place (for example if they decide to defer, or fail an examination). All of the 184 applicants placed on the reserve list in 2010 have since secured a place on the programme, taking up vacant posts created by those who withdrew. Problems may arise, however, if this balance of applications and withdrawals shifts in the future.

^{xxxii}In accordance with European employment law, all eligible applicants must be treated equally during the recruitment process, regardless of their country of origin. Overseas applicants can apply provided that they meet the eligibility criteria. BMJ Careers (2010) 'Foundation Programme Oversubscription'. Available at: <http://careers.bmj.com/careers/advice/view-article.html?id=20001686> [Accessed on 19 July 2011].

Looking ahead there is also some concern about the increasing number of doctors who will be graduating from UK medical schools, and the pressure this may place on applications to the Foundation Programme in future years. In England two reviews have been established to consider these trends. The first, led by the Medical Schools Council and the Department of Health, will capture the number of students in each year at the UK's medical schools, in order to model the likely outputs over the next few years. The second review, by the Health Education National Strategic Exchange will examine the longer term numbers, modelling the impact from 2013 onwards.

Doctors do not have a right to a job for life any more than any other profession, but students who enter medical school 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 their F1 year successfully, which allows them to register fully with the GMC. If the findings of the above reviews confirm that the number of medical school graduates will in the years ahead exceed places on the Foundation Programme, steps will need to be taken to expand the number of places to fulfill this moral obligation.

Doctors not on formal training programmes need access to training and CPD

All doctors, whether they have completed a specialist training programme or not, need to keep their practice up to date. And the speed of medical developments makes the need to do this even greater.

Good Medical Practice requires doctors to keep their knowledge and skills up to date throughout their working lives. Medical royal colleges and faculties set the principles and standards for CPD, and also provide some CPD to their members and fellows. The Academy of Medical Royal Colleges has set out the ten principles for CPD,¹²³ including having an up to date personal development plan, undertaking CPD both inside and outside of one's employing organisation, guidance on documenting evidence, and the role of medical royal colleges/faculties in auditing CPD activities as part of their quality assurance role.

To date our role in CPD has been limited, but we are reviewing this following Lord Naren Patel's recommendation that we should consider our regulatory role in CPD,¹²⁴ ensuring high standards and consistency. We also need to make sure that all doctors have access to the training they need to meet the standards we expect of them.

^{xxxiii} There were 7,257 eligible applications from a total of 7,893 applications submitted. There are certain conditions for eligibility – for example, applicants who have been out of medical school for more than a year will have to pass an assessment of their clinical skills. Applicants from overseas have to provide evidence of their immigration status and information about booking the Professional and Linguistic Assessment Board (PLAB) test by late November.

As we implement revalidation, there will also be an increasing emphasis on CPD. Through annual appraisal, all doctors will need to demonstrate that they remain up to date and fit to practise, and that they are continuing to meet the standards set out in *Good Medical Practice*.

More broadly, for all doctors the pace of change in system organisation and design, and the moves to multidisciplinary team working mean there is an increasing need for ongoing professional development in the areas of leadership and management.

Access to high quality and relevant CPD is vital for doctors not on a formal training programme. This includes both doctors who have already completed their GP or specialist training, and those working as SAS doctors. Given Lord Patel's estimate of up to 20,000 doctors in this latter category, this is a significant part of the medical workforce and there is evidence that, while there have been improvements, it remains under-supported.¹²⁵

There are some inconsistencies in the delivery of medical education, which may impact on good medical practice

Not all medical students and trainees have the same experiences of medical education, and this may have an impact on their subsequent ability to deliver high standards of medical practice.

Pressures of service delivery can compromise protected time for education

Good medical education requires both protected time for relevant learning and practical 'hands on' training. However, the pressure of having to deliver care and treatment can reduce educational opportunity. Medical trainees are often required to provide patient care when there are gaps in rotas. One concern persistently raised with our quality assurance teams (inspectors) and reported by the medical royal colleges and faculties in their annual specialty reports is the tension between the need to provide immediate care and the need for trainees to have dedicated time to learn and be supervised.

This tension has been brought into sharper focus by the introduction of the WTR. In some ways, the restrictions of trainees' working hours has been positive – there is strong evidence of the detrimental impact of fatigue on doctors' performance. Studies in the USA have shown that trainee doctors working shifts of longer than 16 hours make many more serious clinical errors than those working shorter periods.¹²⁶ Those working longer shifts were more than twice as likely to crash their cars commuting to and from work.¹²⁷ Surgical performance is similarly impaired after a single night of sleep loss, with surgeons taking longer to perform operations and making more mistakes.^{128, 129} And patients had twice as many complications if their consultant performed procedures after a night of interrupted sleep.¹³⁰ Similarly, a review of the evidence found that reducing trainees' hours in the USA improved patient

safety and doctors' quality of life, while having no significant effect on training outcome.¹³¹

However, there is evidence that in the UK the most recent reduction in working hours from 56 to 48 hours a week has put increased pressure on service rotas, particularly in acute care. The effect has been a greater reliance on medical trainees to fill the gaps in those rotas, reducing the protected time available for education.¹³² Some royal colleges have also reported that, to achieve WTR compliance, they have had to make significant changes to avoid inadequate specialty experience, insufficient time for training or an overly intense workload.¹³³ For example, the recommended duration of neurology training was extended by a year in the 2010 Neurology curriculum to ensure that all requirements of the curriculum could be met 'particularly in light of changes in training opportunities as the result of the European Working Time Directives'.¹³⁴

As Professor Sir John Temple pointed out in his review of WTR, staff shortages tend to be at night which means trainees can be moved from their daytime commitments at very short notice to fill the gaps. Supervised, planned training opportunities are often lost as a result.¹³⁵

Responses to the 2010 survey of trainees confirmed that the loss of training opportunities continues to

be an issue, and is an area of concern for a significant number of medical trainees.¹³⁶

- 45% of respondents stated that they had had to cover rota gaps.^{xxxiv}
- 23% of respondents stated that they had missed out on teaching or training opportunities as a result of covering rota gaps.
- Only 9% of trainees stated that they had had exposure to extra training opportunities as a result.

Trainees have reported the same problems to our inspectors. These include instances of having to fill rota gaps, leading to lack of training opportunities; an inappropriate balance between meeting the demands of the service and the need to learn; the lack of protected time to attend teaching sessions; and having to undertake tasks of limited educational value.

Using trainees to respond to today's service pressures may compromise the competency and confidence of tomorrow's medical profession. Taking steps to remedy this is not an issue the GMC can, or should, address on our own. The organisation of rotas is a matter for employing organisations. They may need to find alternative solutions, for example by aligning consultant and trainee rotas so that the impact on training becomes less acute. However, the GMC

^{xxxiv}The data do not distinguish how often trainees had to cover rota gaps.

does expect deaneries to act if they believe trainees are not being given the educational experience they need to meet curricula requirements and to develop. We will withdraw approval for training programmes where we are not satisfied that trainees are being adequately supported.

Clinical supervision is variable

Given the challenges faced by medical education, and the variable environments in which learning takes place, it is vital that medical students and trainees have access to high quality supervision. This is particularly crucial at key transition points such as the move into foundation or specialty training when individuals may lack the confidence, or feel under-prepared, for what is expected of them.

Data from the 2010 survey of trainee doctors suggested that there is variation in trainees' experiences of supervision,¹³⁷ including the ease with which trainees were able to access their supervisors.¹³⁸ Some trainees have raised concerns about their supervision to our inspectors during their visits to postgraduate deaneries. Trainees have also reported examples of lack of clinical supervision on the ward, because senior staff were in surgery (although someone was available by telephone), lack of night time cover and educational supervisors not having regular meetings with trainees.

In part, lack of appropriate supervision is just another aspect of the tension between service delivery and education. Trainers' time is not always protected,

and this can result in reduced levels of supervision.¹³⁹ Shift working can also lead to a lack of continuity in supervision. This was a key finding of Cook's review of the Foundation Programme in Scotland, which concluded that shift patterns reduced continuity of contact between trainees and their clinical supervisor and clinical team.¹⁴⁰

Given its importance in medical education, sufficient time for supervision must be included in doctors' job plans, and protected in practice. We know that the picture is mixed across different specialties and different locations. We will continue to monitor this, and will raise issues with employers as required. We will introduce a new framework for the approval of trainers in 2013, which will promote and enhance training both within individual job plans, and within organisations that employ doctors involved in training.¹⁴¹

The learning environment affects medical education

While curricula are crucial in ensuring that *Good Medical Practice* underpins medical education, they are only as good as the environments in which people are learning. Research suggests that medical students and trainees gain from practical experience and positive role models, as well as through evidence-based medicine and clinical protocols.¹⁴² The way in which doctors learn (and subsequently practise) can therefore be influenced by the style and behaviour of the consultant or GP with whom they train, and the team culture in place

at the institutions where they train and work.¹⁴³ So it is vital that doctors, and particularly clinical and educational supervisors, demonstrate effective leadership skills and act as positive role models from which medical students and trainees can learn. This is crucial to ensure that tomorrow's doctors possess the professionalism and leadership they will need.

Results from the 2010 trainee survey underline the relationship between a trainee's perception of the safety culture in the department where they work and the reporting of serious medical errors. Unsurprisingly, trainees were more likely to state that medical errors were reported if they worked in departments where they perceived that reporting was encouraged and followed up (Figure 19). Trainees

were also more likely to report serious medical errors themselves if they worked in a department where reporting was encouraged and followed up.

This latter point is important, indicating that trainees' own practice of reporting serious medical errors is influenced by the culture of reporting in place in the department where they work. Doctors have a crucial leadership role to play in promoting high standards of care. This includes taking ownership for reporting substandard care. The GMC, and others, need to address the challenges that doctors face around raising concerns. This core part of a doctor's professionalism needs to be embedded from the start of a doctor's medical education.

Figure 19: The relationship between a trainee's perception of the safety culture in place and the reporting of serious medical errors^{xxxv}

		Was this serious medical error reported?		
		No	Yes a colleague reported it	Yes I reported it
In this post please indicate your perception of the way in which critical events and near misses were reported in your department	Staff were reluctant to report due to a blame culture	26.1%	21.7%	52.2%
	Reporting was haphazard and not followed up	15.6%	33.9%	50.5%
	Reporting was encouraged and followed up	9.9%	25.7%	64.5%

Source: 2010 national trainee survey

^{xxxv} A chi square test was performed to assess whether there was a relationship between the two question items: 'In this post please indicate your perception of the way in which critical events and near misses were reported in your department?' and 'Was this serious medical error reported?'. This showed strong evidence of a significant association between the two questions.

We are working with others to consider whether, and how, we should approve the educational environments in which doctors train. This could include, for example, setting out how education environments will need to be approved, or developing outcome indicators against which to measure training organisations. As a minimum though, we will continue to work closely with the healthcare organisations in which doctors train, so that we can identify and take action where the environment impacts adversely on the quality of a doctor's training.

Characteristics of individuals can affect experiences and outcomes in medical education

The number of female medical students and doctors is increasing (see chapter 1), and evidence is emerging of some gender differences in the performance of student and trainee doctors.

Medical schools operate their own fitness to practise procedures to ensure students' behaviour is consistent with the professionalism expected of them. These procedures are separate from the GMC's fitness to practise process for registered doctors (described in chapter 3). Only a very small proportion of undergraduates are subject to fitness to practise complaints – in 2010, there were 572 fitness to practise complaints from across 30 of the 32 UK medical schools (this refers to number of complaints rather than students, and more than one complaint may relate to the same student). However, we know from medical school data^{xxxvi} that men are more likely than women to be the subject of fitness to practise complaints.

^{xxxvi} 30 of the 32 UK medical schools submitted information to us based on their 2010 fitness to practise data. Medical schools all have different fitness to practise processes, and varying systems for how they define and respond to fitness to practise concerns.

There are also different patterns in the types of concern reported; in 2010, male medical students were much more likely to face concerns about their conduct – the area in which by far the largest number of concerns was raised about either gender. These conduct issues range from lateness for lectures or clinical placements through to more serious cases of misconduct such as being drunk at a lecture or clinical placement, verbal abuse of a fellow student, plagiarism or cheating in exams. By contrast, concerns about female medical students were more likely to be about their health.

Medical school data also suggest gender differences in failure rates. Overall, the number of medical students^{xxxvii} who fail is very low – 2.8% of all medical students in 2010. However, male students are more likely to fail than female students (this trend is not apparent for graduate entry students). Exam data from the medical royal colleges^{xxxviii} for the 2009-10 academic year also show that the average first time pass rate for specialist and GP trainees in the college membership examinations is slightly higher for women (67.8%) than for men (60.9%)

While the data illustrate some gender differences in medical education, we do not have enough information to suggest why these differences exist. We also need to exercise some caution in how we interpret the results, since a range of factors can affect fitness to practise issues and academic performance.

Gender provides one example, but there are unexplained differences in exam performance across all domains, including ethnicity and country of PMQ.¹⁴⁴ Further research is needed to identify and address what causes these differences. We also need to understand how they might affect the quality of subsequent medical practice (an issue discussed further in chapter 3).

^{xxxvii} This includes medical students on the standard entry undergraduate route, and the four-five year graduate programmes.

^{xxxviii} This does not include data from all UK medical royal colleges. Data from the Faculty of Dental Surgery; Royal College of Ophthalmologists, and the Faculty of Pharmaceutical Medicine were not available.

Conclusion

Medical education and training are being delivered in a changing environment. The challenge to medicine is to adapt to a world of higher expectations and wider responsibilities. Doctors will more than ever be expected to exercise leadership, understand how the systems in which they work operate, and contribute to, and where appropriate lead, multiprofessional teams. To do this, the doctors of tomorrow need structured, consistent and protected training that fosters the principles of *Good Medical Practice*. We and others need to support doctors through education and ongoing training that cover all aspects of what makes a good doctor, in a context that is appropriate to them and to patients.

We know that experiences and performance vary at both undergraduate and postgraduate levels, and we need to understand more about what drives these differences. To do this, we need better data about the current make up of the medical student and trainee population, and about the outcomes of medical education and training.

We also need to remember that doctors do not learn or train only at the beginning of their careers; CPD is critical for the profession as it continues to evolve and respond to changing demands. Revalidation, which will be based on a system of annual appraisal, will also be key in enabling us to understand more about variations in doctors' practice at an earlier point, and to identify the areas in which doctors may require further support. The next chapter looks at these variations in practice in more detail.

A note on data

We have used a range of data for analysis in this chapter. This includes:

- data from the student profile returns we receive from medical schools, which have been used to provide a 2010 snapshot of the absolute numbers of medical students in the UK
- data gathered through our response to concerns process, and by our quality assurance teams (inspectors). Our quality assurance work includes the following:
 - Quality Assurance of Basic Medical Education (QABME) visits to assess how far medical schools meet the standards set out in *Tomorrow's Doctors* (2009)
 - Quality Assurance of Foundation Programme (QAFP) visits
 - visits to deaneries for postgraduate education and training.
- research we have commissioned into medical education and training
- national evaluations of medical education undertaken in recent years (referenced in chapter 3)
- findings drawn from our 2010 national trainee survey. We have used and analysed data from the survey in three ways:
 - the responses provided to questions in the survey so as to gain an insight into experiences and issues affecting trainees
 - to generate demographic data
 - as an approximation for the number of students on the Foundation Programme and the number of specialty trainees.

Data from the national training surveys are based on an 87.5% response rate from the target population of trainees, and so the figures presented here have been scaled up to equal 100% of the target population. The trainee population was defined as all trainees in post within the GMC approved programmes including academic clinical fellowship (ACF)/clinical lecturer (CL) and Foundation Programmes on the census date. However, the target population misses data from a number of individuals:

- trainees on maternity leave at the time of the census
- trainees on out of programme training (OOPT) or out of programme research (OOPR) at the time of the census.

Chapter 3:

Variations in the standards of medical practice

Key information

Our role in fitness to practise is to deal firmly but fairly with doctors who, for whatever reason, are not able to provide safe or effective care to their patients.

We do this by investigating complaints made to us about doctors and determining what, if any, action is needed to protect patients.

In the most serious cases, we can remove a doctor's right to practise medicine altogether but there is a range of other measures we can put in place.

The fitness to practise process stages

The GMC receives complaints from many sources, including patients and the public, doctors, employers, healthcare regulators and public bodies.

Triage

At the first stage – referred to as ‘triage’ – every complaint is subject to a highly structured assessment by the GMC. This is to determine if the information raises a question about a doctor’s fitness to practise that requires immediate investigation. This could be either by the GMC or it could be more appropriate and proportionate for them to be considered locally in the first instance.

If for any reason the complaint does not need to be investigated, it will be closed and the complainant informed that the GMC will not be taking any action.

Stream 2

If the information received is not considered to be serious, but would be of concern 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 (stream 2). We then make a decision about whether there needs to be an investigation.

Stream 1

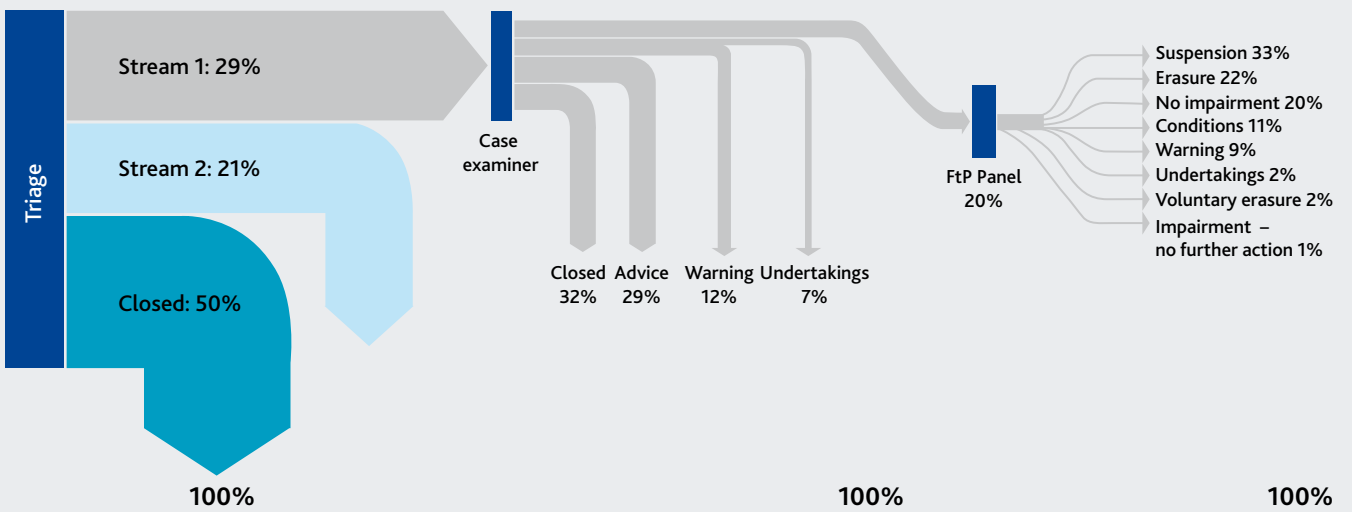
If a complaint raises serious concerns we carry out an immediate investigation. This may include an assessment of a doctor’s health or performance or obtaining an expert report (stream 1) and then referring the findings to staff employed as decision makers. There are five possible outcomes at this stage, the most serious being referral to a fitness to practise panel hearing (see box 4).

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

- whether the facts are proven
- whether 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 (see box 4 on p66).

Box 4: Overview of the fitness to practise process



This diagram is based on the 2010 case volumes and outcomes. The proportions are indicative only as there is not necessarily a linear relationship between volumes and outcomes in a single year. We aim to conclude our investigations and start hearings within 15 months. Therefore, an enquiry received or triaged in 2010 may not result in a hearing taking place in the same year.

At each stage of the fitness to practise process, we close a proportion of cases. At the end of our investigation, a proportion of cases are referred for a hearing. Following a hearing, around one in three decisions in 2010 found the doctor in question not to be impaired – a higher proportion than in previous years.^{xxxix}

However, more than half of the doctors who appeared before a panel in 2010 were either erased or suspended from the register.

^{xxxix} This proportion includes the outcomes 'no impairment' and 'no impairment – warning'. These accounted for 29% of fitness to practise hearing outcomes in 2010.

Standards of medical practice vary

The core professional guidance for doctors, *Good Medical Practice*,¹⁴⁵ is designed to ensure that all doctors practise to the same standards. And, as discussed in chapter 2, these standards should be embedded across all stages of medical education and training. Despite this, we know there continues to be variation in the way doctors practise. The evidence from the UK and around the world is that there are significant differences in patterns of treatment and outcomes and many of these are unexplored and unexplained.^{146, 147, 148, 149, 150} Increasingly, though, the quality of data is improving, allowing institutions, teams and individual doctors to compare their own performance with that of others. Giving doctors access to this information is essential if they are to provide high quality care.

There is evidence that some doctors are falling seriously short of the standards expected of them. The GMC is responsible for investigating and dealing with serious complaints about doctors' practice and this chapter uses the data from this work to look in more detail at these doctors. It also considers information about the experiences of patients and what can be learnt from systemic failures of care.

Perhaps unsurprisingly, the overall picture is of significant variation in medical practice: standards vary, patients' experiences vary, and practice is variable across different groups of doctors. While most patients receive safe and effective care most of the time, the data on patients' experiences and outcomes show that there is considerable unexplained variation in performance at different levels within the system. Much of this may owe more to the way care is organised or to the culture in institutions. But, at an individual level, analysis of the pattern of complaints against doctors may also help us to understand more about why and when things go wrong.

In assessing the state of medical practice today, we need to consider how and how far individual doctors breach standards. This should help provide a better understanding of how medical practice, collectively, can be further improved.

The role doctors play in health systems is crucial to good medical practice

Good healthcare is about more than safe and effective medical interventions. Doctors work within teams and systems, and those systems themselves do not always meet the standards expected. In 2009, the Care Quality Commission in England noted that there was 'unacceptable variation in the performance of services. A small proportion are falling below minimum standards of quality and safety. Some are persistently failing to improve'.¹⁵¹

Patient groups also consistently report that standards are not being met. For example, The Alzheimer's Society found 'unacceptable variation' in the quality of dementia care provided on general wards in hospitals across England, Wales and Northern Ireland. It found patients who were not being helped to eat and drink, that there was less involvement in decision-making than was wished for (both by patients and carers) and that patients with dementia were not being treated with dignity and respect.¹⁵²

Research carried out by the Long Term Conditions Alliance Scotland and the Scottish Government, meanwhile, found that only one in five children living with a long-term condition in Scotland felt that their views were always listened to by health professionals, including doctors, treating them.¹⁵³

A similar theme is evident for cancer patients in England – only 61% of them reported that those

responsible for their care always worked well together. A further 34% did not feel their family had been given enough opportunity to talk to a doctor about the patient's condition.¹⁵⁴

The NHS has also seen several high profile hospital failures in recent years, each of which has produced powerful evidence of what can go wrong, together with recommendations for improvement. The inquiries into events at Bristol Royal Infirmary¹⁵⁵ in the 1990s, at Maidstone and Tunbridge Wells in 2005-06¹⁵⁶ and more recently at the Mid Staffordshire NHS Foundation Trust,¹⁵⁷ have all exposed individual clinical failings of one kind or another, but each one has also demonstrated fundamental flaws in the way care was organised and the culture of institutions concerned.

There has been a growing recognition that safe and effective healthcare requires not only a better understanding of how organisations work and much better information on performance, but also systems for learning from mistakes. As the Department of Health noted in *An organisation with a memory*, 'Human error may sometimes be the factor that immediately precipitates a serious failure, but there are usually deeper, systemic factors at work which if addressed would have prevented the error or acted as a safety net to mitigate its consequences'.¹⁵⁸

An international review of system level failings in healthcare found that while 'on the face of it, the problems often centre on an individual clinician

or small team...organisations where these failures occur usually lack fundamental management systems for quality review, incident reporting and performance management...and frequently show little collaboration between managers and clinicians and a lack of coherent clinical leadership'.¹⁵⁹

Thus, while failures of care may often be beyond the control of individual doctors, doctors are part of the systems that fail, and in some cases (along with other clinicians and managers) may have failed to act on concerns or to take ownership for reporting substandard practice.

As set out in *Good Medical Practice*, doctors must protect patients from the risk of harm including reporting concerns about other clinicians' conduct, performance or health. The growth in fitness to practise referrals from doctors about their colleagues is welcome, but all too often the culture within medical institutions is still not conducive to staff acting on their concerns. This is not a call for a 'blame culture' but for an open and transparent way of working in which even the most junior member of staff feels able to raise issues. As mentioned in chapter 2 (p59), the 2010 trainee survey found that trainees were more likely to report serious medical errors themselves if they worked in a department where reporting was encouraged and followed up. So doctors need to take responsibility both for raising any worries themselves and for supporting more junior doctors to do the same.

The frontline of the regulatory system is on the ward and in the surgery, and part of being a medical professional is to take the necessary steps when there is suspected poor practice. We are committed to raising the profile of this issue and will do so when we publish new guidance on raising and acting on concerns about patient safety later this year. The GMC is investigating a number of doctors in relation to practice at Mid Staffordshire NHS Foundation Trust, some of whom are under investigation 'purely for failure to raise concerns about other doctors'.¹⁶⁰ Equally, when doctors do raise the alarm, they must be protected. In its recent report, the House of Commons Health Select Committee recognised that doctors and other practitioners who have voiced concerns 'have sometimes been subject to suspension, dismissal or other sanctions'.¹⁶¹ This must also be addressed.

Doctors therefore have a crucial leadership role in terms of their own practice, the practice of others and in helping to ensure there are systems in place to deliver care of a high standard. As healthcare is increasingly delivered in multiprofessional teams, doctors' leadership skills will be all the more important since, in many models of care, doctors are responsible for the care delivered by a multiprofessional team. Teamwork skills are also important since doctors may not always be the sole leaders within multiprofessional teams.

A small number of UK doctors fall seriously short of expected standards

Most doctors provide safe and effective care most of the time, consistent with the standards set out in *Good Medical Practice*. Those who seriously or persistently fail to meet those standards should be referred to the GMC. The data about those who are referred thus provide some insight into those aspects of care and professional behaviour where standards are sometimes not being met.

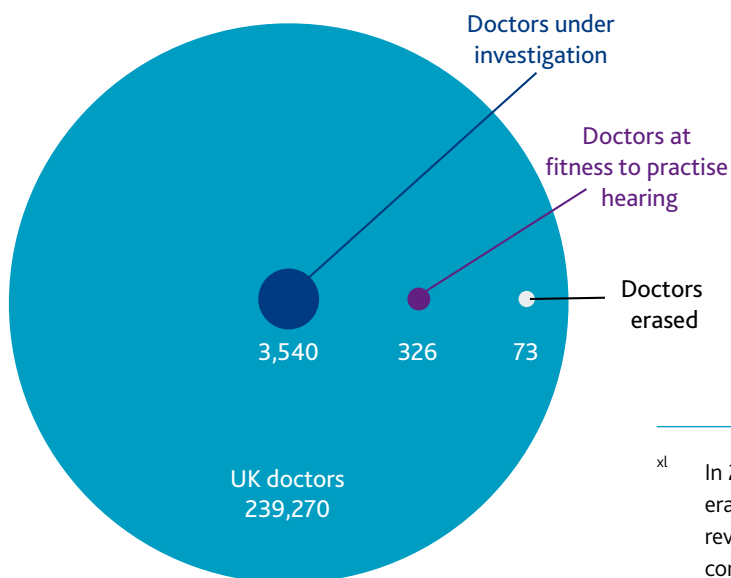
In 2010, the GMC received 7,153 new complaints. Around half were closed immediately because, for example, they were not about doctors or the matter was unrelated to a doctor’s fitness to practise.

We assessed the remaining complaints which concerned 3,540 doctors – around one in 70 of all registered doctors.

Panels who decide if a doctor’s fitness to practise is impaired have a range of sanctions at their disposal – these include erasure, suspension, conditions on practice, undertakings by the doctor, a warning, or no further action.

Of nearly 240,000 registered doctors, 73 were erased ('struck off') from the register in 2010 as a result of appearing before a fitness to practise panel.^{xi} This represents fewer than one in 3,000 registered doctors (Figure 20). A further 106 doctors were suspended for up to one year. Box 4 (p66) shows the breakdown of all panel decisions in 2010.

Figure 20: UK doctors in 2010: only a small proportion were erased
(The size of each circle is proportional to the number of doctors for that category)



^{xi} In 2010, a further seven doctors were granted voluntary erasure from the register and 19 doctors were erased at review hearings which were convened to assess a doctor’s compliance with restrictions previously placed upon them.

Erasure and suspension are the most serious outcomes and, because the numbers are small, they fluctuate from year to year. Over the past four years, the number of erasures has ranged between 42 and 73.

The GMC's data are only part of the picture. The total number of complaints about individual doctors is much greater. Data collected for England by the NHS Information Centre^{xli} give some indication of scale. In 2009-10, there were more than 44,000 written complaints against doctors working in NHS hospital and community health services^{xlii} in England.¹⁶² In Scotland there were around 3,000 such complaints,¹⁶³ and in Wales around 2,500.¹⁶⁴ Not all of the complaints were proven; for instance in Scotland 45% of these written complaints were 'not upheld'^{xlii} And of course there will have been many more oral complaints as well as patients or relatives who decided not to raise their concerns.

It is worth setting these numbers in context – on an average day, the NHS has more than a million patient encounters in general practice alone.¹⁶⁵

Reporting of complaints is increasing

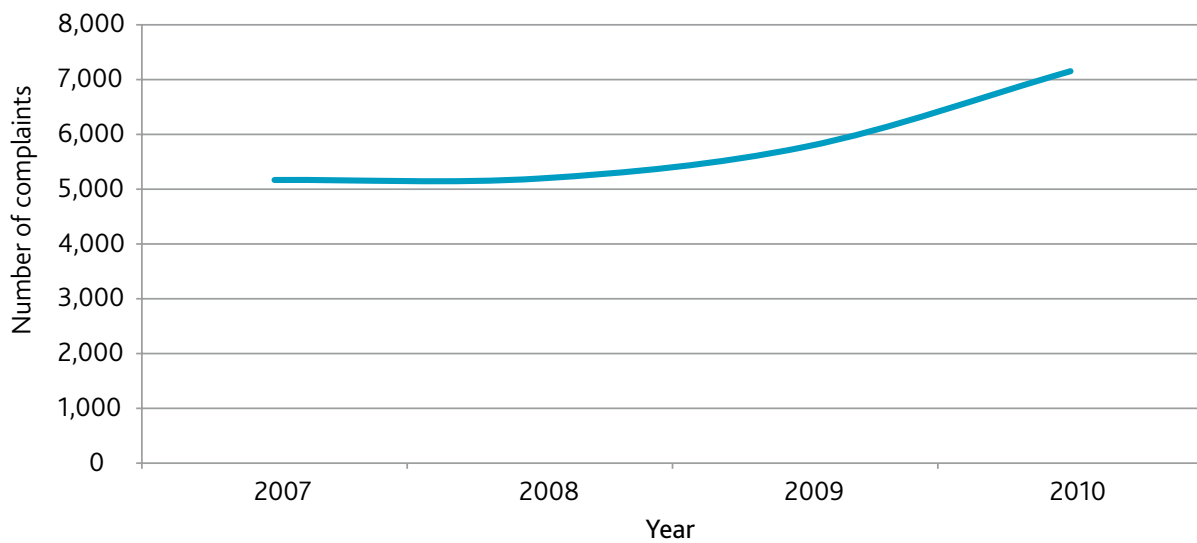
The number of complaints the GMC has received has grown significantly in recent years and has accelerated over the past year, jumping by 24% from 2009 to 2010 (Figure 21). Complaints to the regulators of other healthcare professions show the same trend and in the same period the NHS in England saw its largest ever increase in the number of written complaints about healthcare professionals.¹⁶⁶

We do not know why there has been such an increase – it may reflect a greater willingness to report a complaint or an improved knowledge of the role of regulators – or more likely a combination of factors. Overall satisfaction with healthcare services remains high.¹⁶⁷

^{xli} Reporting data on written complaints in the NHS report is mandatory for all NHS hospital and community services in England apart from NHS foundation trusts, for which it is voluntary; 18 foundation trusts did not supply any data.

^{xlii} The NHS Information Centre in England and Statistics for Wales do not collate the outcomes of written complaints and so do not have a figure for complaints 'not upheld'.

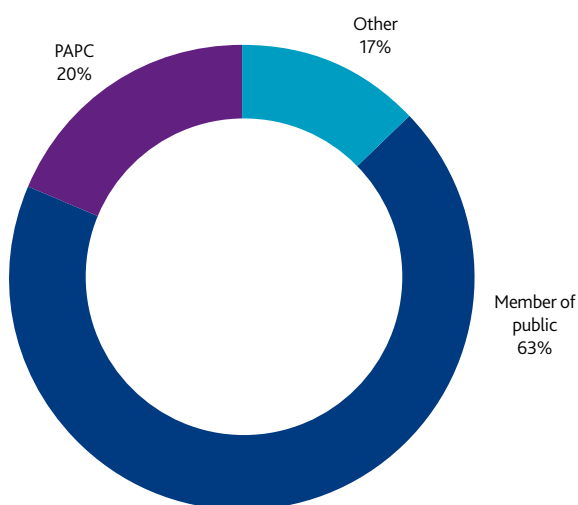
Figure 21: Number of complaints received by the GMC (2007–10)



The majority of complaints to the GMC came from members of the public – 63% in 2010 (Figure 22). A further 20% came from ‘persons acting in a public capacity’ (PAPC) – mostly employers (usually the medical director or a senior doctor), healthcare commissioners and the police.

The remainder came from a variety of sources, including public bodies, other doctors, or media coverage that the GMC followed up on.

Figure 22: Source of complaints (2010)



In 2010, complaints from the public were up by just under a quarter and, compared with previous years, a larger share of these were found to warrant an immediate investigation. Since 2008, there has also been a rise in complaints from employers and police.

To try to establish why this was happening, we commissioned an independent study of the views of medical directors, which has suggested a range of contributing factors.¹⁶⁸

- Changes in public attitudes: reflecting an increasingly litigious culture, awareness of high profile cases, and the impact of the NHS Patient Advice and Liaison Service in England 'which provided patients with access to more opportunities to raise concerns'.¹⁶⁹
- Changes in the attitudes of colleagues: it appears doctors are more likely to refer their colleagues when they are concerned about patient safety.
- Improved governance and management systems: including improved systems for detecting and addressing performance concerns, preparation for revalidation and a greater focus on patient outcomes and safety.

More complaints may look like a problem, but it is much more likely that they reflect, among other things, better governance systems (which detect problems with practice) than deterioration in standards of clinical practice. And good systems should identify problems more effectively and at an earlier stage.

There are common and persistent areas of concern

We classify the concerns we receive about doctors into eight main categories, 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 (Box 5). Of the doctors we investigated in 2010, many had more than one type of concern alleged against them.

Box 5: Categories of concern

- **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/supervision:** honest assessment and appraisal; appropriate supervision; references and reports; appropriate audit and peer review
- **Compliance with GMC investigations:** failure to comply with assessment

Since 2006,^{xliii} there has been little change in the types of concerns most frequently made against doctors. In 2010,^{xliv} the top three types of concerns were: investigations or treatment (clinical care); respect for patients (relationships with patients); and communication (relationships with patients). This is

particularly striking as these are generic features of any professional relationship and cover basic aspects of the interaction between the doctor and patient. Figure 23 shows the most frequent types of concern.

Figure 23 Breakdown of the top three types of concerns* investigated in the fitness to practise process (2010)

*(This does not include concerns that were closed on initial assessment)

Communication		Total	Category and type of concern	Total	Investigations or treatment	Total
Fail to respond to concerns	127		Clinical care – investigations or treatment	2,129	Substandard treatment	572
Fail to provide appropriate information	119		Relationships with patients – respect for patients	468	Suitable action not taken	343
Fail to listen to patient	82		Relationships with patients – communication	466	Inappropriate prescribing	217
Fail to meet communication needs	56		Probity – criminal conviction	290	Failure to diagnose	199
Fail to explain error/issue	21		Probity – writing/signing reports or documents	284	Lack of further investigation	194
Fail to offer apology	16		Probity – conduct	269	Misdiagnosis	157
Fail to respect patient's views	14		Clinical care – record keeping	265	Irresponsible prescribing	143
Fail to explain or share information	8		Clinical care – patient assessment	244	Inadequate follow-up	131
Poor communication with young people	7		Clinical care – patient examination	234	Prompt action not taken	61
Care prejudiced by complaint	4		Working with colleagues – working in teams	200	Delay in diagnosis	45
Fail to assist – possible abuse	4		Health – mental and behavioural illness	199	Withholding treatment	41
Fail to meet language needs	4		Clinical care – referral	197	Prescribing without examination	18
Fail to rectify harm	4		Probity – financial or commercial dealings	174	Prescribing without adequate history	8
			Probity – giving evidence	143		
			Relationships with patients – confidentiality	134		
					Respect for patients	Total
					Rudeness to patient	272
					Fail to respect patient's dignity	84
					Fail to work in partnership	66
					Dishonesty with patient	24
					Verbal abuse towards patient	22

^{xliii} Since 2006, we have recorded data on the specific types of concerns made about doctors.

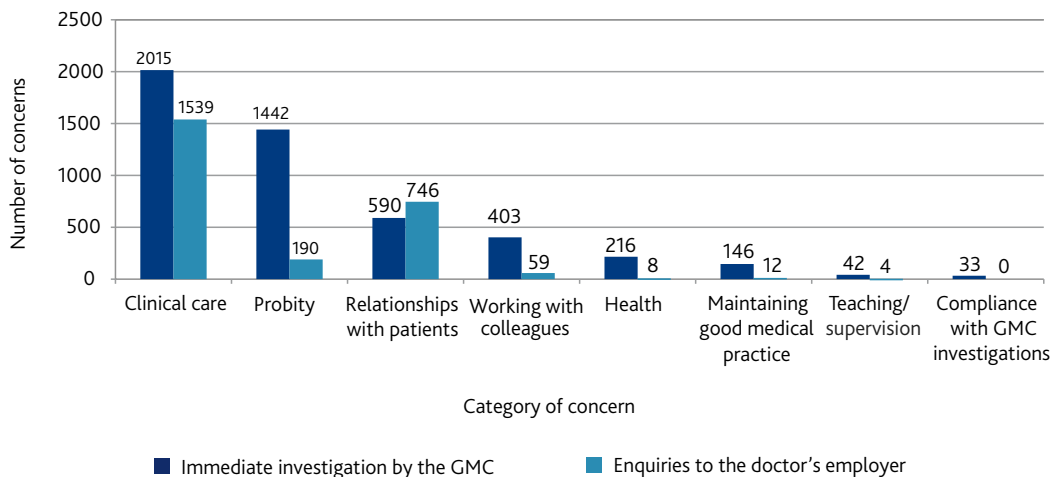
^{xliv} This includes concerns referred either to the doctor's employer (stream 2) or for an immediate full investigation (stream 1).

Different concerns need different responses

Our fitness to practise procedures are designed to deal with a wide range and severity of concerns. Figure 24 shows the eight different categories of concern and whether after the initial sifting we launched an immediate investigation or instead asked the doctor’s employer for more information.

In most cases the complaints that are sent to employers are less serious and more likely to be addressed effectively locally.^{xlv} In 2010, compared with other types of concerns, more complaints about relationships with patients were referred to employers than investigated by the GMC. This is the only category of concern for which this was the case. We rely on employers to take whatever action is needed if the complaint does not subsequently warrant a full GMC investigation.

Figure 24: Number of concerns in each category either immediately investigated by the GMC or referred to the doctor’s employer (2010)



^{xlv} Our data do not track a cohort of cases through the system – rather they allow us to look at the profile of the concerns that were addressed at each individual stage of the fitness to practise process in 2010.

There remains a big proportion of complaints about relationships with patients that we need to investigate.

By contrast, because they are more often very serious, some of the other categories of concern are more likely to trigger an immediate investigation – for example, probity, working with colleagues, health and maintaining good medical practice.

Some of the categories are broad and, as a result, produce variable outcomes. For example, concerns about 'clinical care' can cover anything from misdiagnosis and inappropriate prescribing to poor record-keeping and inefficient use of resources.

At the stage of a panel hearing, clinical care and probity together accounted for almost 71.8% of concerns and 72.9% of erasures. This reflects both the number of such concerns and their seriousness. However, it is also notable that many of the other doctors who were removed from the register faced concerns about relationships with patients, and specifically communication – indicating that poor communication can in some cases have very serious consequences.

There is variation in patients' experiences of medical practice

Analysis of NHS data and surveys suggests that, when patients are asked directly about their recent experience of NHS healthcare, most are positive about the service they receive from doctors, both in hospitals and from GPs. Figure 25 presents a

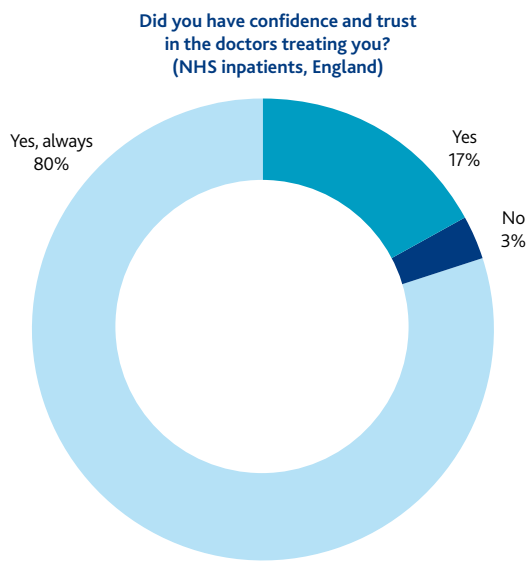
selection of questions and responses from recent NHS surveys across the UK.

The surveys do not ask patients to make judgements on doctors' technical expertise but provide information on various broader aspects of the doctor-patient clinical relationship, including effective communication. It is in some of these areas that some patients identify a need for improvement.

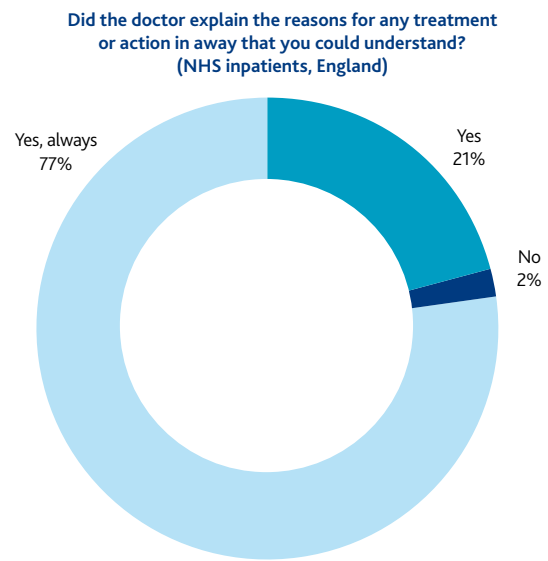
While confidence and trust in doctors remain high and patients' experiences with doctors are generally good (often very good), a small minority of patients report unsatisfactory interactions with doctors and we need more information on why this is so. More common is the sizeable number of responses that suggests the doctor's professional conduct was not of as high a standard as it should have been. For example, among NHS hospital patients in England, one in three say they do not always understand a doctor's answers to important questions;¹⁷⁰ inpatients report that doctors still sometimes talk in front of them as if they were not there;¹⁷¹ and one in five outpatients did not feel the doctor had definitely listened to them.¹⁷²

Around 90% of patient consultations take place in general practice.¹⁷³ Here too, the vast majority of patients report a positive experience, but, in surveys of general practice in England and Scotland, only around half of patients tend to choose the most positive responses when asked about how good the GP was at listening, explaining conditions and treatments, and at treating them with care and concern.^{174, 175}

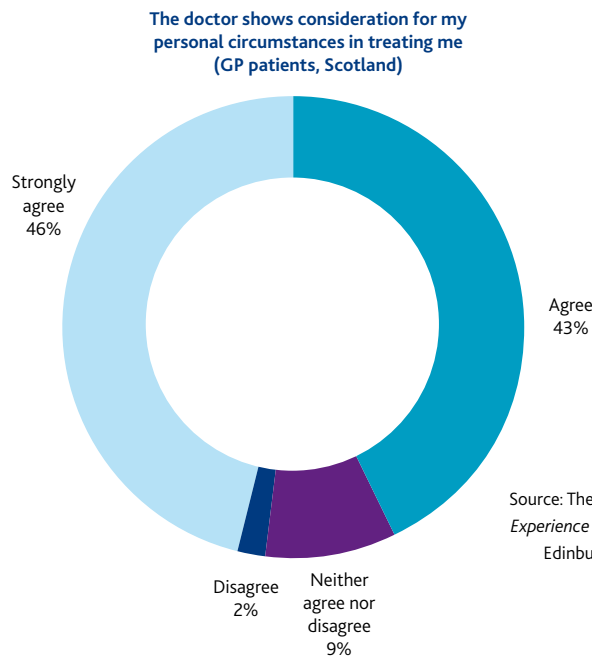
Figure 25: NHS patients generally report a positive experience (figures have been rounded up)



Source: Care Quality Commission (2011) *National NHS patient survey programme, Survey of adult inpatients 2010*. London, CQC, question 32

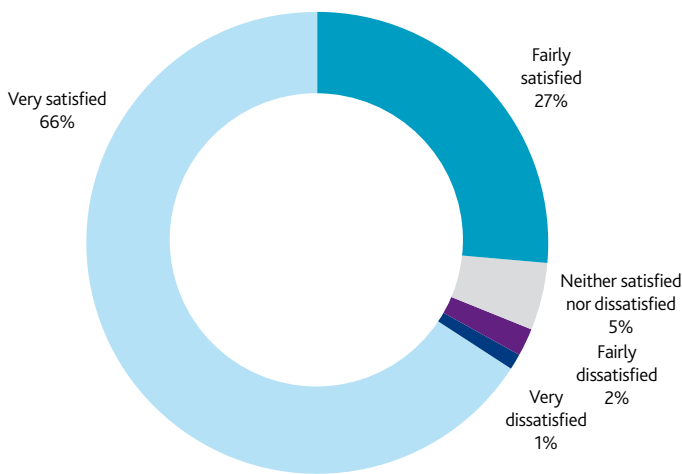


Source: Care Quality Commission (2010) *National NHS patient survey programme, Outpatient department survey 2009*. London, CQC, question 15



Source: The Scottish Government (2010) *Scottish GP Patient Experience Survey 2009/10 national report charts and tables*. Edinburgh, The Scottish Government, question 14c

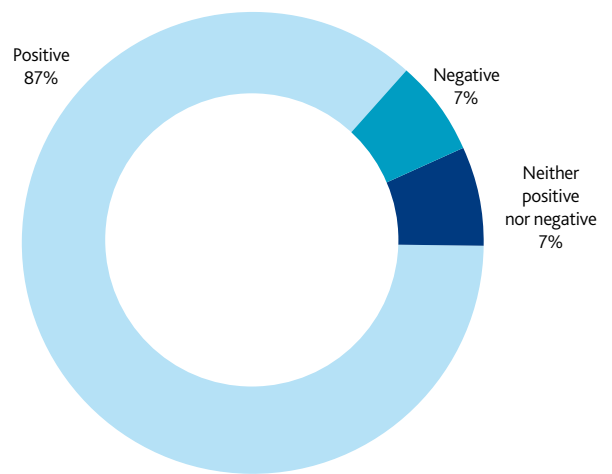
In general, how satisfied are you with the care you get at your GP surgery or health centre? (GP patients, Wales)



(figures have been rounded up)

Source: Welsh Government (2011) *Welsh GP Access Survey, 2010-2011*, Cardiff, Welsh Government, p6, chart 6

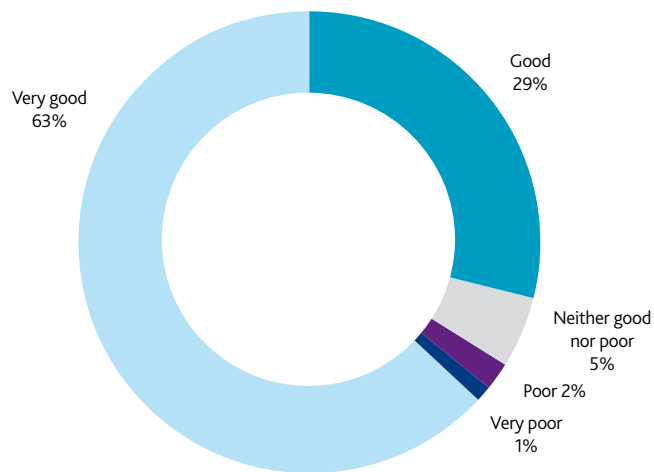
Doctors knew enough about my condition and treatment (inpatients, Scotland)



(figures have been rounded up)

Source: The Scottish Government (2010) *Scottish Inpatient Patient Experience Survey 2010 Volume 1: National Results*. Edinburgh, The Scottish Government, p24, table 6.1

Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at listening to you? (GP patients, Northern Ireland)



Source: Department of Health, Social Services and Public Safety (2011) *The GP Patient Survey in Northern Ireland 2010/11 Summary Report*. Belfast, DHSSPS, p18

There are many reasons why patients may become dissatisfied and it will not always be the responsibility of the individual doctor who is treating them, for instance when there are aspects of the system's organisation or management that patients do not like. Additionally, when services are under pressure and doctors feel they have less time to explain or listen, patients are likely to be less satisfied, as indicated by the survey results above (pp78-79).

Nevertheless, whatever the causes may be, the data from these surveys highlight continuing issues around communication and the attitudes of some doctors towards patients. Perhaps unsurprisingly, these aspects of the doctor-patient relationship are the same as those that showed up so strongly in Figure 23 (see p75) which illustrated the most frequent types of concerns in the GMC's fitness to practise procedures.

Clearly, more needs to be done to improve communication with patients. This is the responsibility of individual doctors, employers, those delivering medical education and the GMC itself.

In the future, better information from patients will help to drive up the quality of care. For instance, measures of patient experience look set to become

more sophisticated not least with the introduction of Patient Reported Outcome Measures (PROMs).^{xlvi, 176} These aim to assess more than the patient's general feeling of satisfaction (or lack of it) about how they were looked after. Instead, PROMs measure how far patients feel the intervention contributed to their overall health. For example a patient may feel they were treated well during their hip operation, but six months later may say that the operation has made little difference to their lives. This type of data will become increasingly important to doctors as they measure their own and their team's performance.

Overall, we must take action to ensure that the doctors who are referred to us go on to improve and provide higher standards of medical practice (unless deemed unfit to practise). We also need to do more to raise the performance of the doctors whose professional conduct does not lead to formal complaints, but who could improve key aspects of the doctor-patient relationship. And, recognising that patient experience is shaped by the systems and environments in which care is delivered, often by a multidisciplinary team, we believe more collaborative working at all levels in the system would improve patients' experiences of healthcare.

^{xlvi} Patient Reported Outcome Measures (PROMs) assess the impact of a specific clinical procedure from the patient's perspective. Self-completed questionnaires before and after an intervention are used to measure a patient's health and quality of life at two points in time and the effectiveness of the intervention. The information provides an indication of the outcomes and quality of care delivered to NHS patients.

There is variation in practice between groups of doctors

Chapter 1 of this report describes the changing shape of the profession, and we need to understand whether these changes are affecting the way in which doctors practise. The proportion of doctors referred to the GMC in any one year may be relatively small (less than 3%) and most of those referrals result in no action. But it is important to understand the pattern of referrals, including who is referred and the nature of the concerns.

We are able to analyse the outcomes of fitness to practise procedures by categories of doctor. These include gender, time since gaining a PMQ, country of PMQ, ethnicity and area of specialty.

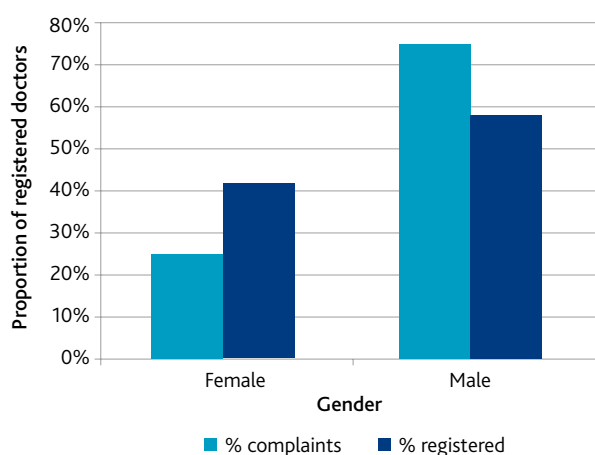
The analysis that follows considers whether the data point to the need for further investigation. It is not an attempt to identify the underlying causes. For example, higher representation of one type of doctor in our procedures does not necessarily mean poorer practice by that group of doctors. In the main we have considered individual characteristics in isolation, and have not corrected for the possible underlying influence of other variables. In any situation there are likely to be a number of factors that affect outcomes. For example, doctors with a certain characteristic may be overrepresented in the fitness to practise procedure. However, these doctors may also tend to work in an area of practice

that is overrepresented. Thus it may not be the characteristic of the doctor, per se, that is behind the overrepresentation – the data can only act as an indicator of some underlying issue. This type of caveat calls for a very considered interpretation of any patterns revealed by our analysis.

We receive and need to follow up on more complaints about male doctors

We received proportionately more complaints about men than women in 2010. They represented just over 58% of registered doctors, but accounted for 75% of complaints (Figure 26). Conversely, while around 42% of registered doctors were female, they accounted for only 25% of complaints.

Figure 26: The proportion of registered doctors and complaints by gender (2010)



This imbalance persisted throughout the stages of our fitness to practise procedures. Complaints about women were more likely to be closed immediately and those that were investigated further were again more likely to be closed with no further action needed.

Male doctors investigated were on average 70% more likely than female doctors to be referred to a public hearing in 2010. However, among those doctors that appeared at a panel hearing, men and women were equally likely on average to be erased from the register, and a higher proportion of women than men were suspended.

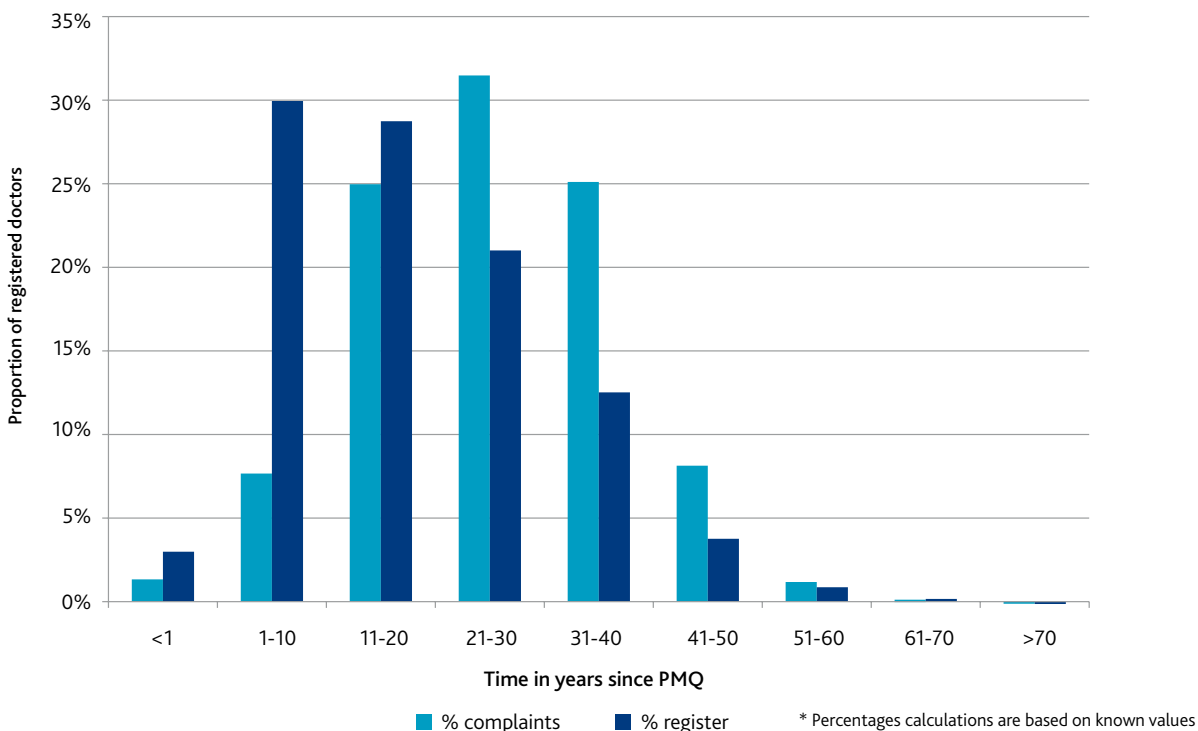
This difference in gender profile has also been found in other countries. In the USA male doctors were

found to be three times more likely than female doctors to be in the high claims category in terms of malpractice,¹⁷⁷ while only 7% of doctors treated for alcohol problems were women.¹⁷⁸ In Norway, of 107 doctors referred to the Norwegian Board of Health over two years, only 16 were women.¹⁷⁹ Further analysis is needed to understand the causal factors behind this trend.

We receive and need to follow up on more complaints about older doctors

Looking at how long it is since the doctor qualified (time since PMQ) shows whether doctors who are less or more experienced are more likely to face fitness to practise procedures. It can also be used as a proxy for age (Figure 27).

Figure 27: Fitness to practise complaints by time since PMQ*



At the initial assessment stage, complaints against doctors were more likely to be closed without action as the age of the doctors increased. This suggests that more experienced doctors were more likely to be subject to complaints that were unsubstantiated or not serious. Evidence about the impact of 'time since PMQ' for later stages of the fitness to practise process is more complex, but, at panel hearings, the older the doctor the more likely on average they were to be erased from the register.

Younger doctors were less likely to face a complaint in the first place, and at a fitness to practise panel hearing were more likely to be suspended rather than erased. The fact that most younger doctors are still in training, and as such will be overseen by a postgraduate deanery structure and by clinical supervisors, may in part explain the fewer complaints against them.

Similar conclusions about age and performance were drawn earlier this year by the National Clinical Assessment Service (NCAS).^{xlvii} Their data revealed higher levels of concern in older age groups, and specifically that 'for doctors, the likelihood of referral [to NCAS] beyond age 60 is about seven times the likelihood below age 40'.¹⁸⁰ NCAS added that this pattern seemed 'to strengthen the case for

educational support for practitioners at later stages of their careers'. The analysis included 5,600 referrals to NCAS since 2001.^{xlviii, 181}

Again it is very important to put this in context – most older doctors work effectively and well and it would be wrong to draw any general conclusions from this data. However it does underline the need for all doctors to keep up to date and the importance of CPD in underpinning good practice throughout a career. The introduction of revalidation from 2012 should ensure that all doctors are maintaining their standards of good practice.

We need to investigate more complaints about doctors qualifying overseas

In 2010, doctors who qualified outside the UK were no more likely than UK qualified doctors to be the subject of a complaint (Figure 28).

However, the GMC closed a lower proportion of complaints against overseas qualified doctors compared with doctors with a UK PMQ. A higher proportion of complaints against overseas qualified doctors were sent for immediate investigation, and a higher proportion were referred to a fitness to practise panel.

^{xlvii} NCAS helps healthcare organisations and individual practitioners resolve concerns about the practice of doctors, dentists and pharmacists, and to make recommendations to support them to return to safe practice. This tends to be the less severe complaints, which can be dealt with at a local level.

^{xlviii} This total includes referrals of dentists.

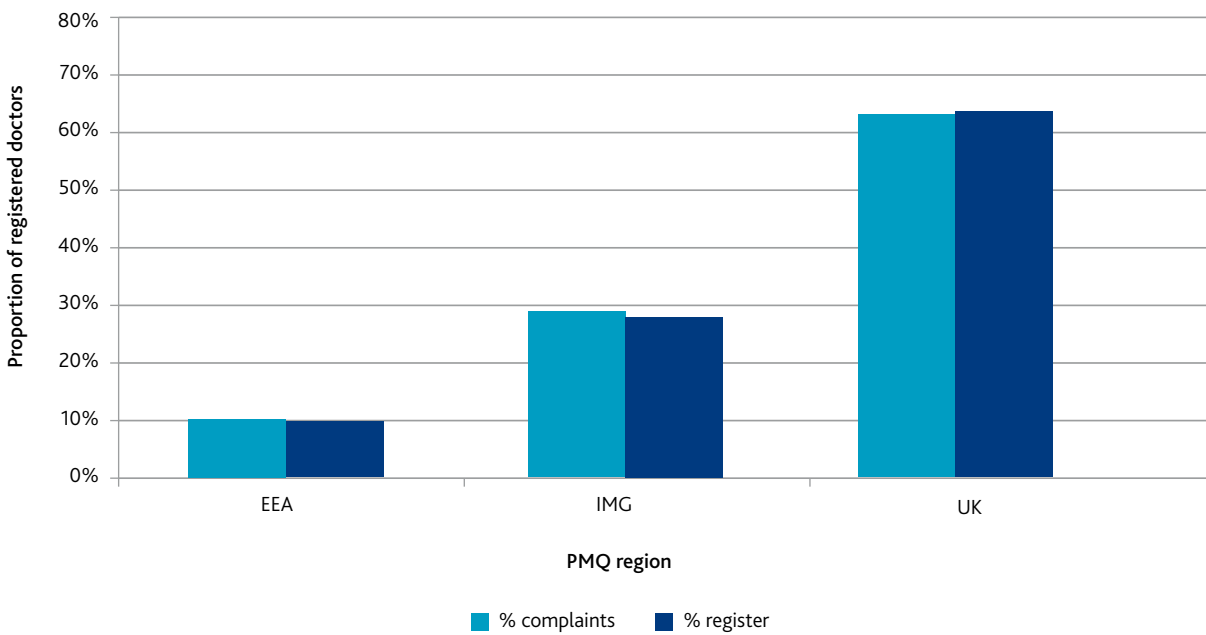
As outlined in chapter 1, as well as doctors with a UK qualification, there are two categories of overseas qualified doctors – those from the EEA and those from other countries (IMG doctors).

While doctors with an IMG qualification were more likely to be erased than UK qualified doctors, they were also more likely than either UK or EEA doctors

to be found not to be impaired and have their case dismissed.

Independent research found fitness to practise data for April 2006 to March 2008 'suggest that non-UK qualified doctors are more likely to receive "high impact"^{xlix} decisions at each stage of the General Medical Council's fitness to practise process. This

Figure 28: Proportion of registered doctors and complaints by PMQ region



^{xlix} 'High impact' decisions cover complaints referred for further investigation at initial triage by the GMC, the proportion of complaints investigated that were subsequently referred for adjudication, and the proportion of complaints resulting in doctors being erased or suspended from the medical register.

association is partially explained, but cannot be fully accounted for, by confounding with other inquiry related and doctor related characteristics that are themselves associated with high impact outcomes'.¹⁸² Unlike the above analysis, this study took into account differences in factors such as gender, age, medical specialty and the nature of the concern. The finding was unrelated to the ethnic background of the doctor – the significant factor was whether the country of PMQ was outside the UK.

The researchers suggested two possible explanations. One was that real differences exist in the fitness to practise of different groups of doctors who are referred to the GMC. A second possible explanation 'is that the GMC processes tend to discriminate against certain groups of doctors'.¹⁸³ However, they cautioned that 'several limitations of the data make it difficult to reach a conclusion that clearly supports either of these potential explanations, and both might be valid'.¹⁸⁴

The recent NCAS research also showed that doctors with a PMQ from outside the UK were more likely to be referred to NCAS, or be excluded or suspended from work (by NCAS), than UK medical graduates.¹⁸⁵

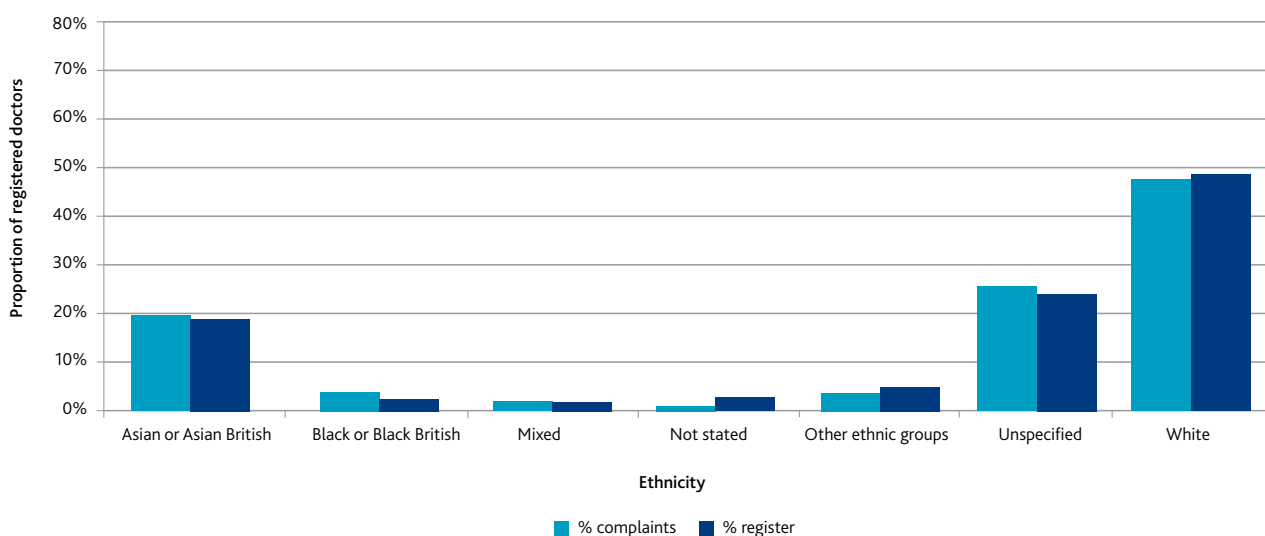
We need to understand this issue better and continue to make sure our procedures are fair and non-discriminatory. We will therefore commission further independent research to increase understanding both of referral patterns and our own processes. We will also continue to work with groups representing overseas trained doctors, encourage a diverse range of applicants to apply to become fitness to practise panellists and provide equality and diversity training for all staff involved in fitness to practise work including panellists.

Ethnicity is not a factor in the number of complaints made or investigated

Doctors do not have to disclose their ethnicity and we do not know the ethnicity of one in four doctors who went through our fitness to practise procedures in 2010. This makes it hard to draw reliable conclusions because the incompleteness of the ethnicity data may mask the real picture.

From the data we do have, there was no evidence of ethnicity playing a role in the likelihood of a doctor facing a complaint in 2010 (Figure 29).

Figure 29: Proportion of complaints and registered doctors by ethnicity (2010)



The independent study of fitness to practise data for April 2006 to March 2008 (described on pp84-85) found that complaints ‘concerning UK qualified doctors showed no association between ethnicity and decision outcome at any stage of the process... Among non-UK qualified doctors... outcomes were generally similar for those whose ethnicity was white or Black and minority ethnic’.¹⁸⁶ However, the authors cautioned that findings with respect to ethnicity ‘must be interpreted cautiously. Different results might be obtained if ethnicity data were available for all doctors’.¹⁸⁷ As reported above, the factor which did appear to impact on fitness to practise outcomes was having qualified overseas, rather than ethnicity.

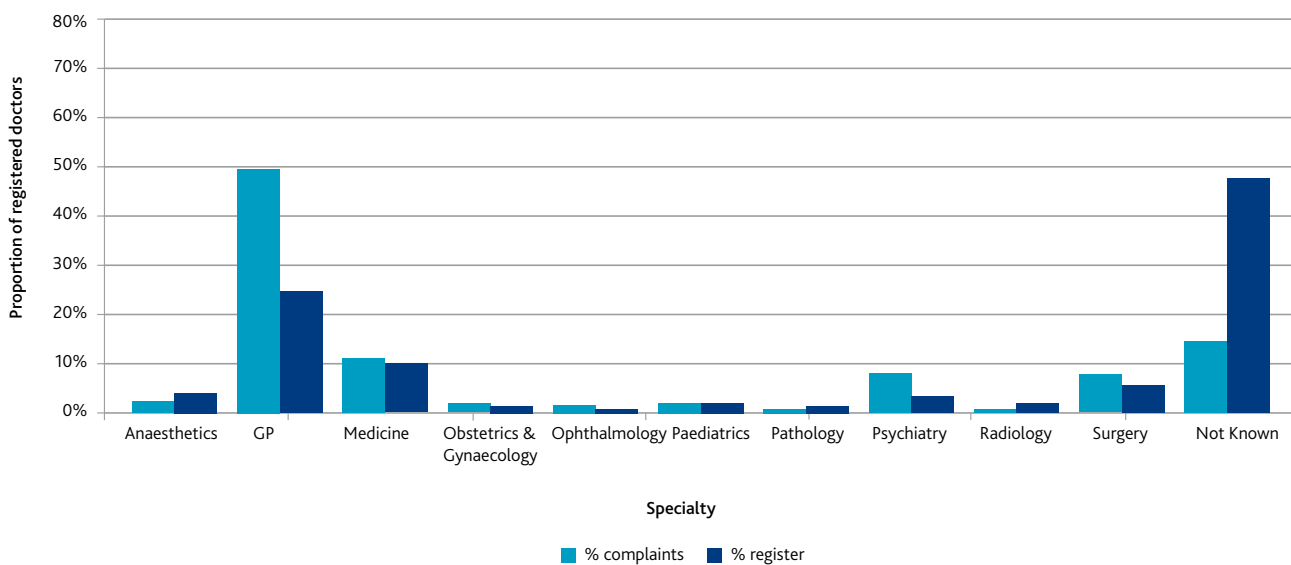
We need to build relationships across the doctor population and we have set up a BME doctors’ forum to help us actively consult with this group. Additionally, we consult with a number of external organisations including BAPIO (British Association of Physicians of Indian Origin), BIDA (British International Doctors Association), BAMA (British Asian Medical Association), and MANSAG (Medical Association of Nigerian Specialists and General Practitioners).

There are differences in numbers of complaints between specialties

A quarter of all registered doctors are GPs, but nearly half of the complaints we received in 2010 were about GPs (Figure 30).

This finding is perhaps not surprising, because most people see their GP more than any other doctor, and the contact is usually one-to-one. In fact, members of the public (patients and their relatives) actually made slightly fewer complaints about GPs than

Figure 30: Proportion of complaints received by area of practice vs proportion on register (2010)¹



¹ This report contains analysis of outcomes at key decision points in the GMC’s fitness to practise procedures grouped by doctors’ area of practice. These groups are based on doctors’ names appearing on the GP and Specialist Registers, where available, and broadly correlate with the ten medical royal colleges of which doctors can be members. This is because, at present, fitness to practise complaints are classified according to specialties included within the remit of medical royal colleges, as opposed to the list of approved specialties.

about other doctors. Many of the complaints about GPs came from medical directors or other doctors.

We closed almost half (45%) of complaints against GPs immediately on the basis that the alleged concerns would never raise a question about fitness to practise, broadly in line with closures overall. However, the largest proportion (36.8%) of doctors appearing before a fitness to practise panel in 2010 were GPs, so GPs are still overrepresented at this stage in our procedures. Data on referrals to NCAS also found GPs to be overrepresented, with 31% of referrals^{li} in 2010/11.

The other areas of practice that accounted for the largest number of complaints were Medicine,^{lii} Psychiatry,^{liii} Surgery^{liv} and 'not known' (see Figure 30, p87).^{lv} Of these, Psychiatry and Surgery were overrepresented relative to their numbers on the Specialist Register.

By contrast, the 'not known' category was considerably underrepresented. This category includes any registered doctor whose name does not appear on either the Specialist or GP Registers. This covers doctors in training grades, and those whose

specialty could not be identified. The latter may include staff grade and associate specialist (SAS) doctors who have specialised in a particular field of medicine but who are not working in an approved training programme. The disproportionately small number of complaints about doctors in the 'Not known' group was consistent with the data in the analysis of 'time since PMQ' as this group will include younger doctors in their first decade since qualification who will be working in closely supervised training settings.

After the initial assessment stage, we were most likely to investigate immediately complaints against doctors on the Specialist Register for Radiology, Anaesthetics and Obstetrics and Gynaecology (for stream 1 complaints).

Only a very small number of doctors from different specialties go through public hearings, which makes it difficult to draw robust conclusions about panel outcomes. However, of the 73 doctors who were erased at panel hearings in 2010, GPs accounted for 27 erasures, which is a higher proportion than that of GPs on the medical register.

^{li} This was calculated with data from the NCAS 2010/2011 Casework Activity Report

^{lii} This includes all medical specialties and sub-specialties within the remit of the Royal College of Physicians.

^{liii} This includes all psychiatric specialties and sub-specialties within the remit of the Royal College of Psychiatrists

^{liv} This includes all surgical specialties and sub-specialties within the remit of the Royal College of Surgeons.

^{lv} This analysis is based on doctors' entry into the Specialist Register, which does not definitively mean that the doctor is currently practising in that field.

We need to do further analysis on the relative probability of doctors working in other (non GP) specialties being referred to the GMC. Once we are clearer about what is happening, we can consider the reasons behind any patterns.

This analysis is at an early stage, and there are still significant gaps in our knowledge. For instance, we have not looked explicitly at the representation of SAS doctors or whether working as a locum doctor (both shown in the 'not known' bar of Figure 30) represents a significant risk factor. We are now collecting data on the scope of doctors' practice and plan to do this for every doctor on the register from 2013.

It is important to recognise where most reported problems come from, but of course this does not establish the cause. The patterns identified by this analysis are just the first step in understanding whether there are particular areas of practice or groups of doctors who need greater support, or where action is required.

We also need a better understanding of other types of patterns in referrals, for instance from looking at referring institutions and geographical spread. We have recently developed the capability to use data on the levels of fitness to practise activity by incident location. We will look for trends at a trust/board level and at a hospital level, and will see if we can identify any common factors among those institutions whose doctors generate a higher level of fitness to practise activity.

As part of this process, we will work more closely with frontline health service employers. To this end, we are currently rolling out Employer Liaison Advisers (ELAs) across the UK to build and maintain our relationships with medical directors, particularly in relation to doctors in difficulty or those involved in our fitness to practise procedures (see chapter 4). Given the limitations of our data, this will help us to understand what lies behind the variations in practice that our analysis has identified and whether further action is needed.

Conclusion

It is clear from our fitness to practise data that a relatively small number of doctors exhibit serious failings (see Figure 20, p70). These need to be dealt with to protect patients, and to ensure that the trust the public has in the medical profession is justifiable.

The patterns in our fitness to practise data indicate the need for further investigation of variations in practice between different groups of doctors, for example as defined by gender, age and country of PMQ.

Just as importantly, there is growing evidence from other sources of variation in clinical performance and outcomes, much of which is unexplained. It is incumbent on everyone with responsibility for medical education and practice to address this with urgency and to ensure that frontline clinicians have the information to assess and benchmark their performance.

In terms of patient experience, there is also evidence of dissatisfaction with some aspects of medical practice. Again much of this needs to be tackled locally. At the same time we and others need to ensure that doctors are encouraged and supported to act when there are serious failings of care in the systems in which they work.

It is not enough to address issues with doctors' practice only when they are brought to our attention by a complaint. We need to act pre-emptively to make sure that today's and tomorrow's doctors are being equipped to meet the requirements of *Good Medical Practice*, and that unnecessary and unwarranted variations are eliminated. This means ensuring that doctors have a full understanding of what is expected of them, that they demonstrate the knowledge and skills needed to meet those expectations, and that we and the wider health system are alerted at an early stage to any actual or potential shortcomings in practice.

This report has looked at the shape of the profession, the state of medical education and training, and the state of medical practice. These areas of investigation are inter-related and are all critical for ensuring high quality medical care. In the final chapter, we review our findings and set out how we are responding to the challenges we have outlined in medical education and training today.

A note on data

This chapter uses data about decisions at various stages of our fitness to practise procedures in 2010. These cases were either reported to us between 1 January and 31 December 2010, or relate to investigations initiated in earlier years which continued into 2010.

It is important to be clear that this means the analysis does not follow a single cohort of doctors through the fitness to practise process. So it is not possible to look at trends between the stages – for example how many doctors about whom we received a complaint in 2010 went on to be erased – because they are very unlikely to be the same doctors.

We have tried to look for patterns in the data by particular characteristics of doctors such as gender, time since primary medical qualification (PMQ), place of PMQ, ethnicity and area of registered specialty. Generally we have looked at each of these characteristics in isolation. Therefore, this means we have not adjusted the results to take account of the underlying influences of any other variables. In any situation, there are likely to be a range of factors that influence outcomes. So, while we can look for broad trends, this limits any interpretation of the

patterns revealed by our analysis, and means we cannot draw conclusions about causality.

Similarly, the analysis of sub-groups of doctors at the later stages of the fitness to practise process is sometimes based on very small sample sizes. This is because relatively few doctors progress to the stages in question. Year on year, there is bound to be some random variation in the data. With small sample sizes, the likelihood that sample proportions may change due to this variation is high. As such, in order to draw conclusions that are statistically significant, larger sample sizes are always recommended. But the nature of our fitness to practise work means we have not been able to achieve this here.

The data in this chapter refer to the medical register as at 31 December 2010 and include provisionally registered doctors. The data as at 31 December 2010 were drawn from the GMC's database during April, May and June of 2011. Our quality assurance processes mean that retrospective data fixes will have been made during this period. As such, there may be slight differences in some of the figures used throughout the report.

Chapter 4:

Achieving better medical practice

This report has shown that the medical profession is changing, the world in which doctors practise is evolving, and that standards of training and of practice vary.

In this chapter we set out some of the key issues that have emerged, and what they may mean for the future of medical education and practice.

There is much to celebrate about the state of the medical profession in the UK. The evidence suggests that most doctors are good doctors, practising within the limits of their competence, providing effective care and treatment for their patients and contributing significantly both to the well-being of individuals and the health of society as a whole. There are high levels of patient satisfaction in doctors and the respect and trust bestowed on them is a testament to their skill and dedication. This level of support is not found in all other developed nations.

At the same time, this report and others have demonstrated that alongside the good care, there are both unexplained and unacceptable variations that need to be acknowledged and tackled. Much of this is about systems and procedures and the way care is organised but, as the GMC's fitness to practise work shows, there is also a small but significant minority of individual doctors whose practice is not safe. The number of concerns made against doctors is growing, although probably not because the problem is growing, but because the profession and the systems in which doctors work are more likely to identify poor practice and to act on it.

At the GMC we are also becoming more aware of variations in the number of complaints about different types of doctors, as well as differences between institutions, teams and areas of the country. Again this may well be nothing new, but our capacity to access and analyse the data provides an opportunity to expose and to try to understand why such differences are occurring.

A changing profession

The report has highlighted that the medical profession is changing rapidly. There are more female doctors, more younger doctors and many in practice who gained their PMQ outside the UK (chapter 1). Those entering the medical profession are more ethnically diverse than the UK population.

Doctors today are training and practising in a complex and changing environment. Political devolution has led to greater differences in the way healthcare is organised and delivered in the four parts of the UK. Ongoing reform, especially major structural change in England, has created further uncertainty both about the future shape of healthcare and its capacity to meet future demand. Equally important, healthcare in the UK, as in other developed countries, faces significant funding constraints. After ten years of unparalleled spending growth, the healthcare systems are now struggling to deliver what is expected from them with the resources they have. Given the wider difficult economic environment, it seems certain that tight and constrained budgets will be a feature of healthcare in the UK for the foreseeable future.^{188, 189}

In recent years, the policy focus has been on improving quality in healthcare. There must now be real concern about how funding constraints could affect the quality of care, including the delivery of education and training for doctors. There needs to be greater transparency in the way in which medical education and training is funded. If medical education and training, including CPD, is to maintain

and improve standards it needs to be protected. There also remains an ongoing debate about how to address the impact of the WTR, both on delivery of care and medical education and training. The GMC and others will continue to monitor the impact of reduced working hours.

Alongside these changes, the practice of medicine itself is becoming more complicated and technically demanding. In turn, that changes the way in which individual doctors exercise their responsibilities. Today's doctors cannot master the vast expansion of knowledge and innovation that is driving forward the boundaries of medical science each day. But they are expected to keep up to date and to know how and when to access information and advice to practise safely and effectively. Their role goes beyond the application of knowledge – they need to be able to synthesise conflicting and incomplete information, deal with uncertainty and manage and communicate risk. In many cases, they need to do this knowing that they must accept ultimate responsibility for the patient in their care.

This report has highlighted some of the challenges faced by the profession across the UK.

We have identified six areas where we believe there is a need for further debate and action. In some cases work is already underway to address these issues, but we think the debate should go further so we set out where more discussion and work may be required.

1. Professionalism and leadership are crucial to good medical practice
2. Regulatory bodies need to redefine how they work
3. Doctors must take responsibility for raising concerns, and need to be supported to do so
4. Overseas qualified doctors need better support
5. Doctors need to be equipped to deal with changing healthcare needs
6. We need to improve our understanding of medical education

Professionalism and leadership are crucial to good medical practice

There has been an ongoing debate about the meaning and place of professionalism in modern medicine.^{190, 191, 192, 193, 194}

Recent events have brought some of these issues to the fore, raising questions about the role of the doctor and the extent to which practitioners should take responsibility for the entire care of the patient and not just for medical interventions. Revelations about appalling care of patients at Mid Staffordshire NHS Foundation Trust¹⁹⁵, the cases highlighted by the Parliamentary Ombudsman in England in her 2010 report¹⁹⁶ and the apparent abuse revealed by the BBC at Winterbourne View may at first sight seem to be

more about nursing care than medical treatment. But if medicine does purport to have a wider leadership role, each of those failures raises difficult questions for the profession.

The term clinical engagement has been much used in the past few years to explain the role doctors have in the leadership and management of the wider healthcare environment.^{197, 198} But there is still evidence that in parts of the system it is not working.¹⁹⁹ Too often when things go wrong doctors have become disengaged or disillusioned and see themselves as being unable to improve or influence the quality of care that patients receive.²⁰⁰

At the heart of much of this is concern that too often the most vulnerable patients are being let down by current healthcare services and the professionals who are supposed to be caring for them. For doctors, the answer must lie in working with other professions, and where that is not happening, they must raise this concern with the organisations in which they work.

We know too from the work on introducing revalidation that effective clinical governance, which must underpin good practice, remains patchy even though there are encouraging signs that this is changing for the better.

In its recent report on the GMC, the House of Commons Health Select Committee called on the GMC to provide greater leadership to the medical profession.²⁰¹ As a regulator, we accept that we do have a key role here – not least by doing everything we can to make sure revalidation becomes a driver for better care by every licensed doctor in the UK, that our standards are understood and that the education and training of doctors is an exercise in continuous improvement. But of course others also have a vital role in making this difference, including the profession itself and those who employ or contract with doctors. The medical royal colleges remain pivotal in championing innovation and the highest professional standards – their considerable influence at all levels in the system will be vital if we are to succeed in continuing to drive up standards.

Professional guidance must be embedded in everyday practice

The core professional guidance, *Good Medical Practice*, sets out what is expected from a good doctor. It defines how patients should expect to be treated and cared for by their doctors. As such, it should underpin a doctor's entire career, from the first day at medical school through to the day they retire from practice.

But of course this is not always the case. Chapter 3 described how a worrying minority of doctors fail to meet minimum standards.

Later this year, the GMC will be consulting on a revised version of *Good Medical Practice* – we hope this will stimulate debate about what is expected from doctors in the 21st century and provide opportunities to explore new ways of making the guidance real for doctors in front line practice. The debate should be about how to maintain and improve standards, including the role of doctors as team leaders who accept and take responsibility for the standards of care provided in the places they work.

We also realise that *Good Medical Practice* must be a living document, which doctors see as immediately relevant and helpful in their daily practice. The web-based tool *Good Medical Practice in Action* is one example of how this can be done. We need to continue to work with doctors and others to develop ways to make the guidance useful to those delivering care.

We know from the analysis of the fitness to practise data that some groups of doctors are more likely to be the subject of complaints, and we should consider in what ways they may require more support from us, employers and the medical royal college where relevant. This includes how we and others might better support sick doctors, and we will be undertaking further research on this as well as reviewing the information we provide on our website.

A fundamental way of making *Good Medical Practice* relevant to doctors' everyday practice will be through revalidation. This will introduce a new form of appraisal based on the principles of *Good Medical Practice*. This will mean for the first time that every

doctor will have to reflect on their practice in the context of *Good Medical Practice* on a regular basis.

Revalidation and employers have a key role in supporting good medical practice

Revalidation is a major change in the way we regulate doctors. From its introduction towards the end of 2012, it will require all doctors to take part regularly in activities to evaluate the quality of their work, including appraisal, clinical audit, case review and clinical outcomes reviews. Doctors will have to demonstrate that their practice is consistent with the standards set out in *Good Medical Practice*. They will have to show that they are keeping up to date, and seeking, and reflecting on, feedback from patients and colleagues.

To support this, every designated organisation must have a Responsible Officer. They are senior medical leaders who must make sure that the right systems, technology and people are in place to enable every doctor to be properly appraised. The support given to Responsible Officers by the chief executives and Boards of healthcare organisations will be crucial in enabling medical leadership and professionalism to flourish. The GMC will be strengthening its ties, and will be working more closely, with health service employers and other key interest groups including independent healthcare providers and those involved in medical education to make sure the new system is successful.

Additionally, we are introducing Employer Liaison Advisers across the UK to support Responsible Officers and others at a local level. We hope this will help to identify problems with practice locally and earlier. Closer collaboration will also help ensure that the wider system deals appropriately with doctors whose performance is not serious enough to trigger a fitness to practise investigation, but who are still failing to meet the expectations of patients.

Good Medical Practice is about more than setting minimum standards

There is also a question about what wider purposes *Good Medical Practice* should serve, and the need to ensure that its standards are continually reviewed so they remain relevant and appropriate. We are revising the current version and, as part of that, we need to consider whether the current standards remain robust and practicable in a changing healthcare landscape.

Good Medical Practice must also be about more than setting a minimum 'bar' below which standards of practice must not fall, or against which disciplinary action is taken. It needs to be a means of promoting clinical excellence and fostering the leadership and commitment that lie at the heart of medical professionalism. There is a need for public debate on these issues, in which patients, employers and doctors can engage to improve the overall quality of medical practice. As we consult on the revised version of *Good Medical Practice*, we will use this as an opportunity to start a discussion on ways of using the standards to promote continuous improvements.

Regulatory bodies need to redefine how they work

Professional regulators such as the GMC are one set of organisations among many with responsibility for the quality of patient care. As well as Governments, employers, professional organisations and individual practitioners, there are now system regulators in England, Scotland, Wales and Northern Ireland.

Professional regulation has undergone massive change in the past ten years. For the GMC this has meant moving away from being part of professional self-regulation to becoming a patient safety organisation, which works closely with the profession to monitor, maintain and improve standards of education and practice but is not run by the profession. Our Council, which oversees our work, now has an equal number of doctors and non-doctors, and we have in recent years become more directly accountable to Parliament.²⁰²

Our relationship with doctors is changing from being one predominantly driven by interactions when their fitness to practise is called into question, to an ongoing relationship which should last the whole of their careers. There has also been a much greater emphasis on education throughout their career. The fact that the GMC now has responsibility for the entirety of medical education means that we can play a more supportive role in fostering good practice as doctors develop and maintain their professionalism throughout their career.

Professional regulation and system regulation must work well together if patients are to be protected

Professional regulation is inextricably bound up with system regulation. If individual doctors are badly trained or practise ineffectively, there will be poor outcomes and unsafe practices at the system level. Likewise, if systems are weak, even good practitioners can fail. Moreover, weak systems allow poor performance to flourish. Many of the failures of care that have generated greatest public concern over the past 10-15 years have been failures both of systems and individual professionals, including the events in Mid Staffordshire.^{203, 204}

The GMC already collaborates and shares information with the other regulators. But we believe more could be done to strengthen the working relationships between, for example, the GMC, the Care Quality Commission Healthcare Improvement Scotland, Healthcare Inspectorate Wales, and the Regulation and Quality Improvement Authority in Northern Ireland, as well as other healthcare professional regulators. We have struggled with this in the past and have had mixed results with initiatives such as the Healthcare Concordat.^{lvi}

Sharing data and analysis is one way of building stronger relationships. For example, the information we hold about the performance of medical education and the views of trainees is of use to system regulators. We also believe we can develop our fitness to practise data to provide a much more comprehensive picture of what is happening in different parts of the profession and the country. By starting to collect and analyse fitness to practise activity by incident location, we should be able to identify trends at a regional and a trust or board level. Often this data will raise questions rather than provide immediate answers about what is going on, but with the introduction of revalidation we should be able to gather a much clearer picture of the state of medical practice. This in turn should help us and others to drive up the quality of the systems within which doctors work.

^{lvi} This is a voluntary agreement between organisations that regulate, audit, inspect or review elements of health and healthcare in England. It was launched in June 2004 by ten organisations, led by the Healthcare Commission.

We are building stronger relationships with the public

In the past, the interaction between the professional regulator and patient has been largely confined to instances when something has gone wrong. In recent years this has begun to change.

We have started involving patient organisations more in our activities, including in the development and testing of guidance for doctors, in inspecting medical schools, and in producing materials for patients themselves. However, we recognise there is much more we can do to build our relationship and visibility with patients and the public. In particular we need to provide better information on what patients should expect from their doctor, and on our role and responsibilities and how we fulfil them.

To do this, we need to provide patients and the public with more and better data on doctors. Informed choice in healthcare requires that patients should have easy access to relevant information about the medical profession. We are committed to increasing the amount of relevant information we hold and publish on doctors. A better informed public may also lead to more and better patient feedback on doctors' standards of practice.

It is no longer good enough for us to wait for matters to be brought to our attention. Our offices in Scotland, Wales and Northern Ireland have already demonstrated what can be achieved through a strong local presence, and we now plan to put in place a network of Regional Liaison Officers across England. This will help us develop our relationships with patient groups and voluntary organisations, local doctors and NHS leaders, local medical committees, GP consortia, postgraduate deans, medical schools, local MPs and others involved in the local health economy.

Doctors must take responsibility for raising concerns, and need to be supported to do so

There is general acceptance now that health professionals can and must be the guardians of patient safety. Anyone who wants a high quality healthcare system cannot accept a culture in which doctors fail to, or feel unable to, raise concerns. Neither should we accept a culture in which professionals who do raise concerns are ignored or penalised. While there are welcome signs in many institutions of a greater openness and willingness to learn from mistakes, we know that more needs to be done.

Good Medical Practice makes clear the standards required from doctors. They must report concerns about colleagues where they feel that patient safety is at risk. We are doing more to make sure that this guidance is understood, including working more closely with employers so that they can better support doctors in meeting these standards.

We know that in the past some people have raised concerns about being punished for 'whistleblowing'. That is totally unacceptable. We also need to move the debate on from negative perceptions to a positive affirmation of institutional cultures where professionals can acknowledge individual errors, learn lessons and where concerns that are raised are heard and acted on. This must also be about the important leadership role that doctors play in raising concerns and protecting patients. It is at the heart of medical professionalism and needs to be more fully acknowledged as such. To help with this, we will be issuing new guidance and extending our support over the coming year. We will also explore the idea of setting up a new confidential helpline service for doctors concerned about professional issues.

Overseas qualified doctors need better support

Doctors who come to work in the UK make a vital contribution to our healthcare system, but we must make sure they receive the support they need to practise safely and to conform to UK standards.

Doctors who have been trained in the UK have been exposed at an early stage to professional standards and UK healthcare systems. More needs to be done to ensure consistency of induction for overseas trained doctors, so that they can gain an early understanding of the ethical and professional standards they will be expected to meet, as well as familiarity with how medicine is practiced in the UK.

While there are some good local schemes for supporting doctors who are new to this country, there are too many examples of new doctors undertaking clinical practice with little or no preparation for working in the UK.^{205, 206, 207} There have also been accounts of locum doctors being sent to undertake duties for which they have not been appropriately trained.²⁰⁸

As a contribution to help support doctors who are new to UK practice, we intend to work with employers and professional organisations to develop a basic induction programme. Ideally we believe that all doctors should have to complete the programme before they practise, whether they are trained in the UK, elsewhere in Europe or further afield as everyone who treats patients needs to be supported to do that safely.

All doctors practising in the UK must have adequate English language skills

There are particular issues about the English language capabilities of doctors whose first language is not English. This is true for doctors who qualified in the EEA as well as those who trained in other countries.

The current system for assessing and guaranteeing proficiency in English is not satisfactory for doctors from other EEA states. Doctors trained elsewhere in the world are required to demonstrate they have the necessary knowledge, skills and English levels to practise medicine in the UK. Most do this by passing the Professional Linguistics Assessment Board (PLAB) test run by the GMC and by achieving satisfactory scores in the International English Language Testing System (IELTS). In 2010, we raised the required IELTS pass score for overseas doctors wishing to practise in the UK. However, we are prevented by UK law from assessing the language skills of doctors from the EEA. We believe this needs to change.

The GMC is currently working with the Department of Health (England) in an attempt to resolve this. It is unacceptable that the current system enables doctors to practise in the UK without a sufficient grasp of English.

Whatever reforms emerge, however, there remains a duty on those who employ or contract with doctors to make sure that all their medical staff can adequately understand and speak English, and that

they will be understood by patients and colleagues. We are not convinced that all employers are fulfilling this duty. Furthermore, if a language problem is subsequently identified, employers need to support the doctor and make sure they reach an adequate level of competency to be safe to continue to work.

Doctors need to be equipped to deal with changing healthcare needs

The core principles of *Good Medical Practice* must be embedded throughout all stages of medical education and training, both through the curricula and in the culture of the learning environment. Findings from our 2005-10 cycles of inspections of medical schools suggested that more can be done to ensure that professionalism is central to undergraduate medical education. We can no longer assume that appropriate professional values and behaviour can be unconsciously learned during the undergraduate course.

At the postgraduate level, we have already set out generic outcomes for training in our guidance *The Trainee Doctor*.²⁰⁹ However, we believe we can do more to develop a core set of outcomes for training, which go beyond specialty specific skills and knowledge. These would cover key components of *Good Medical Practice* such as leadership, communication skills, maintaining partnerships with patients and sharing information with professionals on safe and effective care.

The maintenance of professional practice, including the acquisition of skills and knowledge is lifelong for a doctor. CPD is in part what defines a professional. As has already been discussed, revalidation will provide a strong mechanism to help ensure doctors are keeping up to date.

Medical practice needs to meet the healthcare demands of the future and the changing expectations of patients

Shifts in the prevalence of different types of disease have always changed the nature and pattern of medical practice. The current trends should be no exception and they will call for a different balance between specialties. This may cause tensions because the areas of medicine in which doctors are in demand are not always those in which young doctors want to specialise. For some time there have been shortages in certain specialties and over-subscriptions in others. The medical profession will also have to find the right balance between specialists and generalists, not least to support the continuing transfer of care from acute to community settings, and the increasing number of people living with chronic disease, many with comorbidities. As a result, there is need for a debate on the number of specialties in the UK and whether they are appropriate to our future needs. The relatively large number of specialties in the UK compared with many other countries seems complicated, and may be difficult for patients to understand.

Curricula will need to change. While Foundation doctors must continue to have access to patients with acute illness and learn how to manage them effectively, they also need exposure to patients who have chronic conditions and comorbidities, which require long-term management. Increasingly, these patients are being cared for by multiprofessional teams in community settings. At an undergraduate level, medical students need to be given appropriate exposure to a variety of clinical settings.

There is also a need to address the relative inflexibility of the current arrangements which do not allow trainees to move between specialties once they have entered higher specialty training. Given how long it takes to qualify in some areas of practice, this needs to be looked at both in terms of creating a system that can adapt to changing demand and accommodate changing career choices of individual trainees.

There is already a debate underway on how to produce the doctors the UK will need. The large expansion of medical students in the past decade²⁰⁹ should mean that the UK is less reliant on overseas trained doctors, but the pattern of medical practice is changing. The medical royal colleges are asking about the future role of consultants and the structure of their training, while departments of health and employers are considering how the workforce demands and the expectations of doctors will affect the shape of the medical workforce.

We believe there should be a fundamental review of the shape of postgraduate training and we are in discussion with the four departments of health, the Academy of Medical Royal Colleges, the Medical Schools Council and others about taking forward a review of the shape of postgraduate training. In our view, this work needs to be focused and time limited with conclusions by the end of 2012.

All of this takes place against the backdrop of the WTR, the implementation of which continues to pose challenges for the delivery of medical care and medical education and training. We believe that equipping trainee doctors for practice requires them to have sufficient, protected time for education. We expect employers and the profession to adjust working practices and rotas to achieve the correct balance. We are starting to understand the impact of WTR, and we will continue to look at this issue, including where necessary commissioning further research.

Medical schools' recruitment processes need to be fair and transparent

The point of entry to medicine is through selection to medical schools. Those who select medical students have a huge responsibility for ensuring that we have the right people to be the doctors of tomorrow. There has been significant progress in this, and in many ways medicine is more diverse than other professional groups.

We are working with the Medical Schools Council and others to identify examples of good practice in selection of medical students, based on the best available evidence. If necessary we will commission further research. One area would be to consider predictors of performance and whether these might be used to inform student selection processes used by medical schools.

Universities have a duty to make sure their selection processes are fair and consistent, and that they do not discriminate. There does need to be a better sharing of best practice across UK medical schools in this important aspect of work.

The GMC does not have responsibility for selecting students – that is a matter for each medical school. But we are concerned that schools should draw from the widest pool possible, including those who are currently under-represented, such as those from lower socio-economic groups and Black men.

In recent years, the issue of access to traditional professions such as medicine has attracted attention and study, notably in the UK Government's 2009 *Unleashing Aspirations* report.²¹¹ A number of medical schools have also established widening access programmes, intended to encourage applications from under-represented groups. Programmes like this should be more widely implemented across all of the UK's medical schools, and better dissemination of learning and good practice will be crucial in supporting this.

Additionally, while medical schools need to make sure that students receive adequate support, they must also take appropriate action when a student's performance fails to meet the required standards. We know from data on failure rates that different groups of medical students have different outcomes, for example, failure rates are higher for men than for women. It is important that medical schools respond to these trends, and the needs of different groups, and provide whatever support is necessary.

We need to improve our understanding of medical education

For many not involved in medical education and training, it must appear an obscure and complex world. The public needs to be provided with more information so they can better understand medical education and training. Recent programmes such as Modernising Medical Careers have demonstrated this complexity, and the difficulty of changing the system. This complexity can also make it difficult to collect data and information. Medical education involves a series of rotations; medical students and trainees make a number of transitions between the different stages of education and in the process often move physically between different parts of the UK. As a result, information can be dispersed over a range of bodies and organisations, and too often it is not shared between them. We are concerned that there is a lack of useful information on both the inputs and outputs of education and training.

We also need better data on outcomes – greater transparency here will benefit everyone involved. There are already examples of good practice such as the way some medical royal colleges (the Royal College of Physicians, the Royal College of Anaesthetists, and the Royal College of General Practitioners) publish their examination data. We believe all colleges should publish this information. In 2013, we will begin evaluating the impact of *Tomorrow's Doctors* (2009), which sets the standards for undergraduate education. Our aim is to be able to provide greater assurance about the consistency in the skills and knowledge of the students graduating from UK medical schools.

There is also a need for more information for patients and the public so that they better understand how medical education and training works and the vital role played by doctors in training in delivering frontline care.

Better information would support medical students and trainees in making career decisions

As healthcare needs change, and the structure of training adapts, doctors' career decisions will increasingly need to take into account the changing requirements of, and demands on, the health service. Already we know that mismatches exist between the profession and the system – for example, the availability of Foundation Programme places, the supply of doctors in rural areas, and the variation in competition for training places across different specialties.

Those going through medical education and training programmes need information to guide their career decisions, especially in the context of higher student tuition fees and the likelihood that many more will carry larger amounts of debt into their professional lives. Both students and trainees need clear reliable information on competition rates to enable them to balance their personal career aspirations against future job opportunities. In this context, it would be helpful if medical schools and the Medical Schools Council, postgraduate deaneries and the medical royal colleges could work together, drawing on workforce intelligence from across the UK.

Next steps

Effective regulation must not overburden the system it oversees, and its interventions must facilitate, not hinder, good practice. At the same time, we are clear that professional regulation is changing and that we need to be more proactive. This report is one way in which we are trying to achieve this. Its aim is to promote discussion and debate on issues and trends that require attention or further analysis.

We intend to build on this by putting more of our data and commentary in the public domain. We plan to publish *The state of medical education and practice* annually and support it with further data and discussion. This first edition seeks to open a debate, but in future years we hope to focus on specific issues in more detail.

Our aim is for the GMC to add value by learning from our interaction with the system and the individuals within it and by reflecting back what we have learnt. In this way, we hope to improve the quality of medical care provided to patients throughout the UK.

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Glossary

Academy of Medical Royal Colleges

The Academy promotes and coordinates the work of the medical royal colleges and faculties.

An organisation with a memory

This report is about what we can learn from things that have gone wrong in the NHS. It was produced by an expert group led by the Chief Medical Officer and published in 2000. The report made a series of recommendations, including the establishment of a national system for reporting and analysing adverse healthcare events, and improved local systems.

Associate specialist, staff grade doctor or specialty doctor (collectively known as SAS doctors)

Doctors who are employed by the NHS but not as a consultant and are not in formal training programmes to become so. These doctors work under the supervision of a consultant. SAS doctors were previously known as non consultant career grade doctors (NCCG).

British Medical Association (BMA)

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.

Care Quality Commission (CQC)

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.

Category of concern

As well as recording individual concerns, we group these together into broader categories. We do this at three levels: category, type and sub type.

Centre for Workforce Intelligence (CfWI)

The CfWI is responsible for NHS workforce (ie staff) planning and development in England. The CfWI models future workforce needs and so that the NHS and social care providers can plan for them.

Certificate of Completion of Training (CCT)

A CCT confirms that a doctor has completed a GMC approved training programme following a GMC approved curriculum. When a doctor has their CCT, they are listed on our GP Register or Specialist Register. Legally, to practise as a consultant or GP in the NHS, a doctor must be listed on the Specialist or GP Register respectively.

Certificate of Eligibility for General Practice Registration (CEGPR)

CEGPR is a route to join the GP Register for doctors who have not completed a GMC approved training programme. They may have a combination of training and experience gained in the UK or overseas that is considered by the GMC to be equivalent to the CCT curriculum.

Certificate of Eligibility for Specialist Registration (CESR)

As above, this is a route to join the Specialist Register for doctors who have not completed a GMC approved training programme.

Clinical supervision

This is a formal way of supporting doctors' learning. Every doctor in training must have a named clinical and educational supervisor. 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.

Concerns

Concerns are the issues someone has complained about, ie what they say has gone wrong. The way we describe concerns follows our guidance *Good Medical Practice*. We record the outcome of each concern separately (for example in a single case, some concerns may be found proven and need action and others may be found not proven).

Continuing professional development (CPD)

CPD supports doctors' ongoing learning so that they continue to develop their skills throughout their career.

Core specialty training

Training for some medical specialties is broken down into two parts: 'core specialty training' followed by '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.

Council for Healthcare Regulatory Excellence (CHRE)

This organisation oversees the nine health professional regulators, including the GMC, in the UK. It does this by:

- reviewing and assuring performance of the health professional regulators
- auditing the initial handling of fitness to practise procedures
- referring cases to court when decisions are considered too lenient
- advising on policy about the regulation of health professions.

Employer Liaison Adviser (ELA)

ELAs are employees of the GMC who have fitness to practise expertise, and who work with medical directors both in the NHS and the independent sector to support them in dealing with concerns about doctors, specifically fitness to practise and revalidation.

Equivalence routes

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.

Erasure

A doctor's name can be erased from the medical register so that he/she 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.)

European Economic Area (EEA)

The European Economic Area (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.

Fitness to practise

A doctor's fitness to practise medicine is their ability, or willingness, to provide safe, high quality care.

Good Medical Practice 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.

Foundation doctor

A doctor who has graduated from medical school and is now continuing their training in the Foundation Programme (see below).

Foundation Programme

A two-year 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.

F2 trainees are fully registered and licensed.

Good Medical Practice

Good Medical Practice 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.

The guidance is written for doctors to follow in their work, but it also lets patients know what they can expect from doctors.

GP consortia

Groups of GPs (normally based in the same area) who work together to commission health services for a defined local population.

GP Register

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, providing they also gain access to a performers' list.

GP trainee

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.

Higher specialty training

Following successful completion of core training, trainees are eligible to apply for higher specialty training. Specialty training (including GP training) programmes vary in length and are tailored to the needs of the specialty. The medical royal colleges and faculties have produced national curricula for each training programme to meet the standards required by the GMC. On successful completion of higher specialty training, doctors receive a Certificate of Completion of Training (CCT) or a CESR/CEGPR via the combined programme route and are placed on the Specialist or GP Register.

International English Language Testing System (IELTS)

This is the system used to test people's English language skills. It is run in over 100 countries. International Medical Graduates (IMGs – see below) are required, by law, to show that they have the necessary knowledge of English to practise medicine in the UK, and achieving the required scores in the IELTS test is the way most IMGs demonstrate this.

International Medical Graduate (IMG)

IMGs are those who do not benefit from EC rights and are:

- nationals of a country outside the UK, EEA or Switzerland who graduated from a medical school outside the UK or
- UK nationals who have graduated from a medical school outside the UK, EEA or Switzerland.

Licensing/licence to practise

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 that they are in good standing with the UK medical regulator.

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.

Medical register

The medical register is publicly available and searchable on our website and 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.

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 its 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).

National Clinical Assessment Service (NCAS)

NCAS provides support to healthcare organisations and individual practitioners to resolve performance concerns about doctors, dentists and pharmacists. It makes recommendations to support them to return to safe practice.

National Expansion of Medical Schools (NEMS)

NEMS was a programme that increased the number of places for medical students in UK medical schools between 1999 and 2001, to respond to the need for more doctors.

The Higher Education Funding Council for England created a total of 2,145 new medical school places. As a result:

- almost all of the existing medical schools received new places
- four new medical schools were established
- graduate entry four year courses were introduced.

National training surveys

Each year the GMC conducts surveys of postgraduate trainees and trainers 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.

NHS Education for Scotland (NES)

A special health board in Scotland with responsibility for the development and delivery of education and training for all NHS Scotland staff.

NHS Information Centre

The NHS Information Centre collects, analyses and publishes data about the NHS in England, including information on:

- population health analysis and surveys
- health screening
- clinical quality
- prescribing
- adult social care
- NHS workforce.

NHS Patient Advice and Liaison Service (PALS)

PALS offers confidential advice, support and information to patients, their family and carers. This includes information on NHS complaints procedures.

**Out of programme training (OOPT)/
out of programme research (OOPR)**

Experience gained by trainees outside of their official training programme. Periods out of programme may count towards the award of a CCT when prospective approval is sought from the GMC.

Patient Reported Outcome Measures (PROMs)

PROMs assess the impact of a specific clinical procedure from the patient's perspective. Patients complete questionnaires before and after a medical intervention (for example, an operation) and these are used to measure a patient's health and quality of life at two points in time. This information is then used to provide an indication of the outcomes and quality of care delivered to NHS patients.

Persons acting in a public capacity (PAPC)

An individual acting on behalf of an organisation.

Primary Medical Qualification (PMQ)

The qualification gained on successful completion of an undergraduate (or graduate) medical degree.

Postgraduate deanery

Deaneries are regional bodies that oversee the delivery of postgraduate medical education, including the continuing professional development of all doctors and dentists.

Professional Linguistics Assessment Board (PLAB)

PLAB is the main way that IMGs prove that they have the necessary skills and knowledge to practise medicine safely in the UK. Currently, the following groups of people are required to take and pass PLAB before they can apply for registration with a licence to practise in the UK:

- nationals of a country outside the UK, EEA or Switzerland who graduated from a medical school outside the UK
- UK nationals who have graduated from a medical school outside the UK, EEA or Switzerland
- doctors without European Community rights or not sponsored under a GMC approved arrangement, or holding an approved postgraduate qualification.

Regional Liaison Officer (RLO)

RLOs work with postgraduate deans, medical schools, local medical committees and other local bodies. Their role is to strengthen our relationship with all those who have an interest in our work.

Responsible Officer (RO)

ROs 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.

ROs will also ensure that systems of clinical governance and appraisal in their organisation are working and are appropriate for revalidation.

ROs 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 RO.

Revalidation

Revalidation is the process by which licensed doctors will, in future, regularly demonstrate to the GMC that they are up to date and fit to practise.

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.

At the end of each revalidation cycle, normally every five years, ROs will make a recommendation to the GMC about whether each doctor should be revalidated based on feedback from their appraisals throughout the cycle.

Run-through specialty training

Trainees on run-through training progress through each stage of their specialty training automatically, provided that they have met all of the competency requirements. They complete a single programme of training and do not have to compete for places at each stage in the same way those doing core and higher specialty training do. (See core specialty training and higher specialty training above).

Specialist Register

The Specialist Register lists all doctors who 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.

Specialty trainee

A doctor on a postgraduate specialty training programme.

Sub-specialty

A narrow field of study or work within a specialty. There are currently 35 approved sub-specialties within the 61 specialties approved by the GMC.

Suspension

A doctor can be suspended from the medical register so that he/she cannot practise during the period of suspension. Suspension is a possible outcome of our fitness to practise procedures.

Uncoupled training programme

Uncoupled training programmes are split into two parts: core specialty training and higher specialty training. Trainees do two years of core training (three in some cases), then compete for higher training posts in which they complete their specialty training.

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 practice, which could include restricting their practice 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, for example if they have retired from practice, 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.

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Authors

Luke Bruce (Editor)

Paul Haward

Ross Hutchison

Elizabeth McGrath

Elizabeth Hopper

Anna Perkins

Teresa Poole

Notes



Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: **0161 923 6602**

**General
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Council**

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Ensuring good medical practice