

Summary: *The state of medical education and practice in the UK: 2011*

The state of medical education and practice uses General Medical Council (GMC) and other data to provide a picture of the medical profession in the UK and to identify some of the challenges it faces.

Why is the GMC publishing this report?

In the past professional regulators have tended to be reactive – but if we are to improve standards of care for patients we believe we need to be more positive and engaged, working more closely with employers, doctors and patients. The report is a step in helping us achieve this.

We hope it 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. We believe that by sharing the data, knowledge and insight we have gathered through our work we can better protect patients.

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 help 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 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 variations that need to be better understood and explained.

We plan to publish *The state of medical education and practice* annually. This first edition seeks to open a debate, and in future years we plan to focus on specific issues in more detail.

About the report

The full 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.

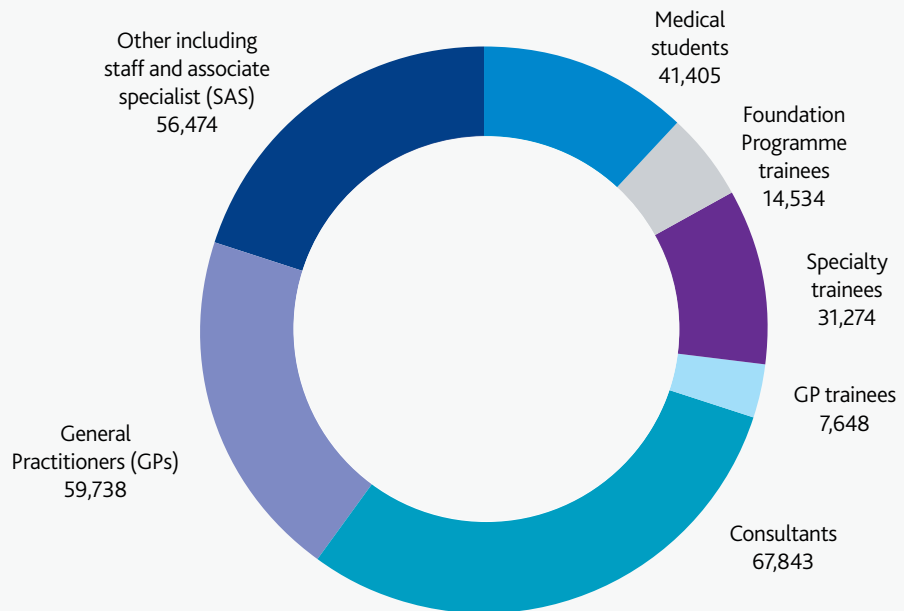
The final chapter, *Achieving better medical practice* (chapter 4), considers what changes may be required to meet existing and future challenges.

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

Who are today's doctors? Key facts 2010

- 239,270 doctors were on the medical register, of whom 226,682 held a licence. Doctors registered with us across the UK were as follows:
 - England: 178,301
 - Northern Ireland: 6,415
 - Scotland: 19,849
 - Wales: 10,510.
- 139,381 (58%) registered doctors were male and 99,889 (42%) were female.
- The average age of registered doctors was 39.9 years; the mode was 33 years.
- 37% of registered doctors qualified outside of the UK.
- 48% of registered doctors described themselves as white, and 26% as Black and Minority Ethnic (BME). However, we did not have ethnicity data for 26% of doctors.**
- After General Practice, the three specialties with the largest number of doctors were: Anaesthetics (9,728), General Psychiatry (4,851) and Paediatrics (4,498). Though, when combined, the nine surgical specialties accounted for the largest number of doctors listed on the Specialist Register (11,373).
- According to World Health Organisation data, the UK has one doctor for every 365 people, similar to the USA, which has one doctor for every 375 of its population.

Make up of the UK medical profession (2010 snapshot)***



* These numbers were based on each doctor's registered address. Other categories include: non-UK; Channel Islands and unspecified.

** Of the 26% of doctors we did not have ethnicity data for, 2.6% chose an explicit 'not stated' category.

*** 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. Foundation Programme trainees include those students who are enrolled on the Foundation Programme and have not yet entered specialist or GP training.

The medical profession is diverse and changing

It is important to understand the composition of today's doctors so we can better support them to deliver the best possible care. Employers and others will also need to accommodate changes in the profession.

■ The number of female doctors is set to overtake male doctors between 2017 and 2022

- 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.

■ The average age of doctors is falling

- The younger age profile will lead to a shift in the balance of experienced to inexperienced doctors. This may have implications for training and service delivery.

■ More than a third of registered doctors qualified outside the UK

- In 2010, around 150 countries were represented on the UK's medical register. After the UK, the country with most doctors on the UK register was India (see below).

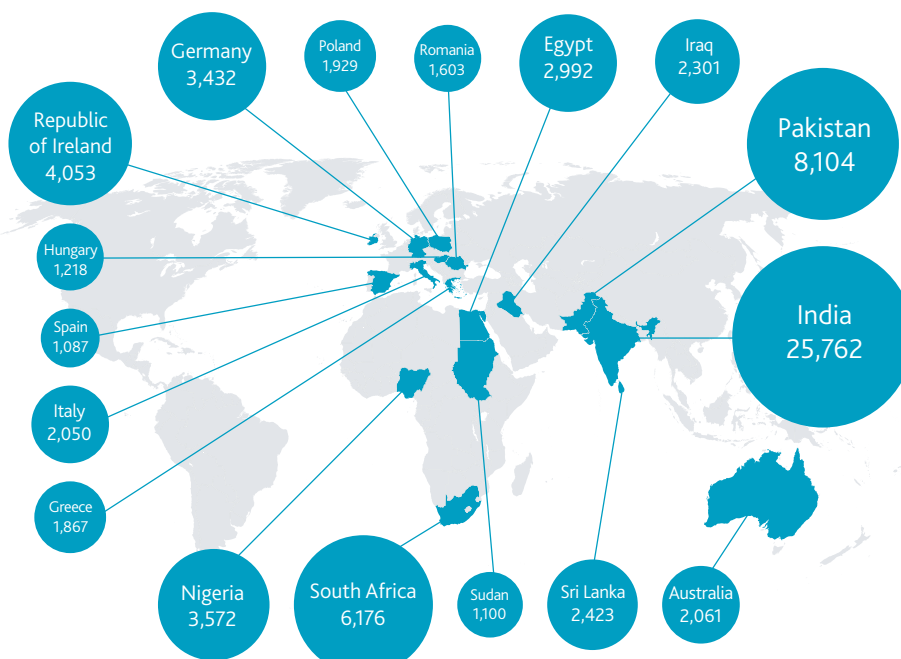
■ The medical profession is ethnically diverse compared with the UK population

- Despite this, some groups continue to be under-represented in the medical workforce and medical student population.

■ Doctors work in many different medical specialties, sub specialties and areas of special interest

- The GMC currently approves 61 specialties and, within these, 34 approved sub-specialties.
- Men and women make different specialty training choices. There is a higher proportion of women in Palliative Medicine, Family Planning and Reproductive Health, Clinical Genetics, and Child and Adolescent Psychiatry. Anaesthetics, Ophthalmology, Gastroenterology and the surgical specialties have a higher proportion of men.
- Medical practice will need to meet the challenge of treating a population of older patients with one or more chronic diseases. In particular, this will put greater pressure on primary care.

Non-UK qualified doctors on the UK register (top 17 countries)



Medical education plays a key role in supporting good medical practice

Medical education and training are being delivered in a changing environment and need to keep pace with technological developments and rising patient expectations. Doctors need lifelong structured, consistent and protected education that fosters the principles of *Good Medical Practice*.

■ 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 new roles as a consultant or GP.
- However, in the past, some medical graduates reported being unprepared for some of the practical skills needed when they entered Foundation training.

■ Medical education and training need to better respond to changing patterns of healthcare

- Foundation doctors need exposure to training across all care settings and in multidisciplinary teams.
- Medical students and trainees need better information to make their career choices, including information on competition rates

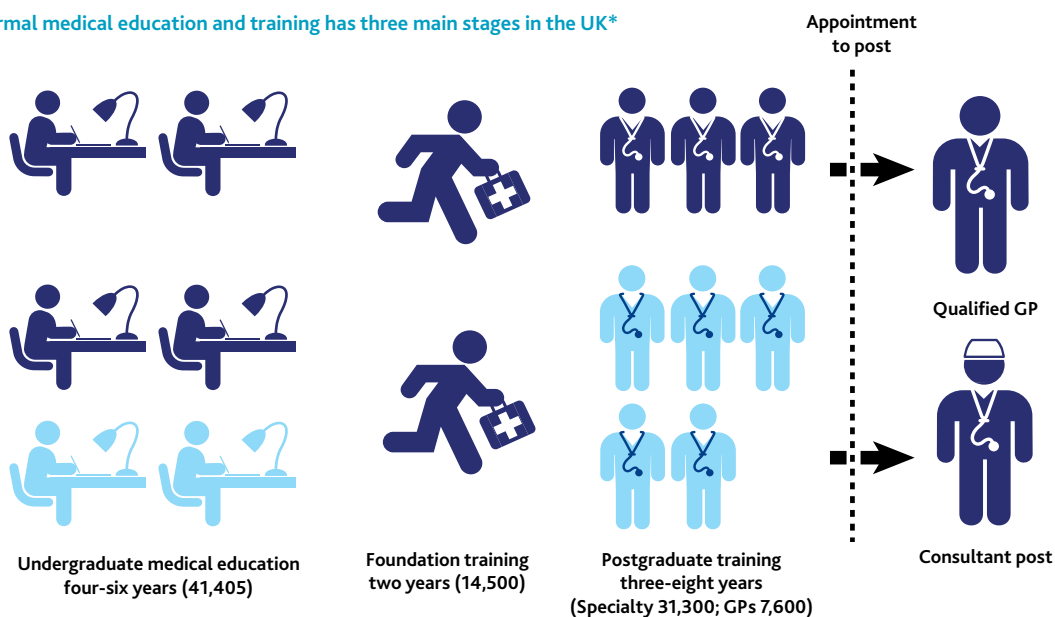
and the likelihood of success in one's preferred career choice.

- Given the speed of medical developments, all doctors need to keep up to date through continuing professional development. This is particularly crucial for doctors not on formal training programmes.

■ There are some inconsistencies in the delivery of medical education

- There is a tension between service delivery and protected time for education and training, and this has been exacerbated by the 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.
- How doctors learn can be influenced by workplace culture. In a survey of trainees, 64.5% working in organisations where reporting was encouraged said they were more likely to report a serious medical error, compared with 52.2% working in organisations where staff were reluctant to report errors.

Formal medical education and training has three main stages in the UK*



* The estimated figures for Foundation trainees and specialty trainees are based on the results of the national trainee survey. 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.

There is unacceptable variation in the standards of medical practice

While most patients receive safe and effective care most of the time, there is unexplained variation in medical practice. Analysis of fitness to practise data can help us to understand when and why things go wrong. It is not enough to address issues with doctors' performance only when they are brought to our attention. We need to act pre-emptively to make sure that today's and tomorrow's doctors are being equipped to meet standards required of them.

■ A small number of UK doctors fall seriously short of the standards expected of them

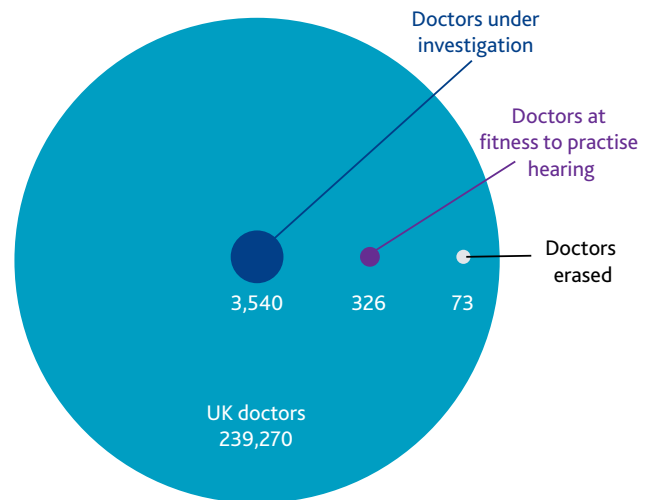
- The GMC received 7,153 new complaints in 2010. Around half were closed immediately because, for example, they were not about doctors or the matter was unrelated to a doctor's fitness to practise.
- We assessed the remaining complaints which concerned 3,540 doctors – around one in 70 of all registered doctors.
- Of nearly 240,000 registered doctors, 73 were erased ('struck off') from the register in 2010, representing fewer than one in 3,000 registered doctors.

■ There are common and persistent areas of concern

- In 2010, the top three types of concerns were about clinical investigations or treatment, respect for patients, and communication with patients.
- This is particularly striking as these are fundamental parts of any professional relationship and cover basic aspects of the interaction between the doctor and patient.

■ There is variation in patients' experiences of medical practice

- NHS surveys conducted across the UK suggest that confidence and trust in doctors remain high, and that patients' experiences with doctors are generally good and often very good.



- However, there is evidence that doctors' communication with patients could be improved – for example, in a survey of patients in England (2009), one in five outpatients did not feel the doctor had definitely listened to them.
- We 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.

■ There is variation in practice between different groups of doctors

- We receive proportionately more complaints about men than women. In 2010, 75% of complaints were about men (who make up 58% of registered doctors), compared with 25% about women.
- We receive and need to follow up on more complaints about older doctors.
- We need to investigate more complaints about doctors who qualified overseas.
- We receive more complaints about GPs than other types of doctors – a quarter of all registered doctors are GPs, but nearly half of the complaints we received in 2010 were about GPs.

Next steps – key areas for further debate and action

Professional regulation is changing and we need to be more proactive. This report has highlighted some of the challenges faced by the profession across the UK. We have identified six areas for debate and action to further improve the quality of medical care provided to patients.

1. Professionalism and leadership are crucial to *Good Medical Practice*

- *Good Medical Practice* must be immediately relevant and helpful to doctors' daily practice. To make it a living document, we developed a web based tool, *Good Medical Practice in Action*. We will continue to develop ways to make the guidance useful to those delivering care.
- Revalidation, a system whereby all doctors will need to demonstrate their ongoing fitness to practise to the GMC, will help by bringing every conversation about a doctor's performance back to the standards set out in *Good Medical Practice*.
- We have set up a new team to support employers in all aspects of medical regulation, particularly in relation to fitness to practise referrals and Revalidation.

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.
- Professional and system regulators need to work more closely together – for example, by sharing data. We are starting to collect and analyse fitness to practise activity by incident location to help identify trends at a regional and trust or board level.

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

- Doctors must report concerns about colleagues when they feel that patient safety is at risk. We will be issuing new

guidance on this and will extend our support over the coming year.

- There are actions here too for employers. We cannot accept a culture in which doctors fail to raise concerns or in which those who do are ignored or penalised.

4. Overseas qualified doctors need better support

- Doctors who come to work in the UK make a valuable contribution, but we need to make sure they receive the support they need to practise safely.
- 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 or elsewhere.
- Employers need to be confident that their medical staff can speak and understand English to a good enough standard.

5. Doctors need to be equipped to deal with changing healthcare needs

- There needs to be a debate on the number of specialties in the UK and whether they are appropriate to changing healthcare needs.
- We believe there should be a review of the shape of postgraduate training, so that it is flexible enough to meet shifting patient and service requirements.

6. We need to improve our understanding of medical education

- 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 begin evaluating the impact of our updated standards for undergraduate education, *Tomorrow's Doctors* (2009).