

General
Medical
Council

The state of medical
education and practice
in the UK

2015

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A new data resource

for *State of medical education and practice* readers

For the first time this year we are publishing online a large set of data tables to accompany the *State of medical education and practice 2015*. These tables comprehensively cover GMC data relating to the register, medical education and fitness to practise. They summarise the source data used to create many parts of this year's report. They are available at www.gmc-uk.org/somep2015.

For those wishing to access the tables quickly to look up specific facts, the tables are in Adobe Acrobat (pdf) format laid out in a standardised, way that is easy to navigate. For those wishing to do further analysis, the tables are also provided in Microsoft Excel (xls) format.

We have developed this resource following feedback on previous issues of the *State of medical education and practice* and in line with our wish to be as transparent as possible about the data we hold. We hope that it will be useful for a wide range of purposes and to many different people including general policymakers, patient groups, doctors interested in particular medical policy issues, educationalists and researchers. We would welcome feedback on the usefulness and use made of these online data tables at gmc@gmc-uk.org.

The tables are grouped into six separate files, each including its own detailed table of contents, to make finding specific data easier.

1 Who is on the register of medical practitioners?

These tables are based on data from the List of Registered Medical Practitioners (LRMP), for each of the years 2010 to 2014.

Some of the tables include all registered doctors, but most relate to licensed doctors only. The numbers of doctors on the GP Register, the Specialist Register, both registers, and neither register are presented. For those on neither register, the number who are in training is also provided.

The data are further broken down by:

- age group
- gender
- ethnicity
- the world region in which a primary medical qualification was obtained
- the doctor's main specialty.

Separate sets of tables are presented for each of the 13 main specialty groups, such as medicine, paediatrics, and surgery.

2 How does the make-up of the register differ by country and region?

These tables are also based on data from the LRMP. A mixture of these data, combined with employment and other data, is used to locate doctors into particular countries and regions on the basis of where they were working at the end of 2014. Tables are presented by UK country and, within England, by Government Office Region.

Analyses of all registered doctors and all licensed doctors are presented, together with the numbers of licensed doctors on the GP Register and the Specialist Register. For those doctors on neither register, the numbers who are in training and of those not in training are also provided.

The data are further broken down by:

- age group
- gender
- ethnicity
- the world region in which a primary medical qualification was obtained.

3 and 4 Doctors in training and where these trainees are located

These tables are based on registration data combined with national training survey census records to locate doctors in training into particular countries and regions on the basis of where they were training at the end of 2014. Tables are presented by UK country and, within England, by Government Office Region.

The data are further broken down by:

- age group
- gender
- ethnicity
- the world region in which a primary medical qualification was obtained
- training pattern ('full time' and 'less-than-full time').

5 Medical students

These tables are based upon the Medical School Annual Return (MSAR) provided to the GMC. They cover medical students studying in the UK for each of the academic years 2011–12 to 2014–15.

Student numbers are broken down by:

- gender
- ethnicity
- nationality
- UK country of medical school and, within England, Government Office Region of medical school.

Separate sets of tables are presented for standard entry programmes and for graduate entry programmes.

6 Fitness to practise

These tables are based upon registration data combined with management information arising from the GMC's Fitness to Practise (FtP) work. Data are presented for each of the years 2010–14 and for the whole period 2010–14, except when the numbers for individual years are so small that there is a risk that individuals could be identified. In these cases only data for the whole period 2010–14 are shown.

When interpreting these tables, it should be borne in mind that several doctors may be involved in a single FtP process, and one doctor may be involved in several processes during the period reported. About half of the tables count the number of particular FtP processes or outcomes, and about half count the number of doctors involved in those processes or outcomes. The tables cover FtP enquiries, complaints, investigations, and panel hearings of different types.

The data are further broken down by:

- age group
- gender
- ethnicity
- the world region in which a primary medical qualification was obtained.

Overview

This is our fifth annual report on the state of medical education and practice in the UK. It sets out what is happening in relation to the education and practice of doctors in this country, and considers some of the current challenges facing the medical profession and the systems in which it works. The report uses data gathered by the General Medical Council (GMC) as well as that of other organisations working in this field. Inevitably, much of the data is for the full year 2014, but we have also drawn on more-recent intelligence where that is available.

A year of political and structural changes

At the front line of clinical care within many medical specialties, the past year has been characterised by increased demand and significant financial and service pressures.^{1,2} Since the inception of the National Health Service (NHS) in 1948, the UK healthcare system has been used to annual growth in real terms of, on average, about 3%. But in the past six years, following years of very large rises, growth has barely kept up with inflation.³ Unsurprisingly therefore, there have been real challenges in managing current demand within both medical education and medical practice, and in devising ways of shaping the future.^{4,5,6}

Against this background, there is strong anecdotal evidence across the profession that many doctors are frustrated and that there are signs of disengagement and disillusion. Involving and valuing clinicians at all levels in service design and improvement is going to be essential if the current financial and service challenges are going to be met.

Plans for seven-day-a-week services and structural reform

For some time, governments have recognised that fundamental changes to the way services are organised will be needed if the system is to be sustainable.⁷ The NHS has introduced some major new initiatives in 2014–15 as part of its medium-to-long-term plans.

The new UK Government, with its responsibilities for England, has backed the implementation of the Five Year Forward View as set out by NHS

England, and the health secretary has set out a 25-year vision for seven-day-a-week services.⁸ The case for more senior medical cover at nights and weekends was first raised in the 2013 edition of this report⁹ along with the need to make sure that doctors have access to the right diagnostic and other support to make them effective if they are on duty.

In 2011, the Scottish Government laid out a framework for efficiency and productivity in response to service pressures.¹⁰

The prospect of further structural reorganisation – especially in England – will cause many to fear more disruption and distraction from the task of delivering good care. But the hope is that the changes will be much more about where and how care is delivered, and that they will create a system in which demand is managed more efficiently with effective care and support provided at the right point for patients. Without simply spending additional resources, it is difficult to envisage an alternative approach.

The report by Lord Rose¹¹ suggests that delivery in England may become an issue, not least because of a shortage of experienced managers to deal with the major changes when they are introduced.

The extent of funding pressures is certainly evident, with NHS trusts and foundation trusts in England forecasting a 2015 end-of-year deficit of more than £800 million.¹² The scale of the financial deficit is not explained simply by the increasing number of trusts in deficit, but also by the increasing size of deficit at many of these providers.

Service pressures and postgraduate education

Service pressures can be the result of shortages, for example there not being enough doctors in certain specialties or in specific areas of the country. There have been reports of shortages of doctors training in acute medicine and geriatric medicine,¹³ at a time when data show that many specialties are increasingly relying on older doctors and non-UK graduate doctors. Rural areas, particularly in Scotland, are also experiencing a shortage of doctors, which is putting the health service in those areas under strain.¹⁴

More demand on accident and emergency departments

One obvious manifestation of the service pressures has been the high number of patients turning up at accident and emergency departments.

Accident and emergency attendances in England have risen by 1 million (4.6%) over the past five years, from 21.4 million in 2010–11 to 22.4 million in 2014–15.¹⁵ The percentage of patients meeting the four-hour target from arrival to discharge, admission or transfer has fallen from 97.4% in 2010–11 to 93.6% in 2014–15. In the first quarter of 2015–16 (April to June) it was even lower at 91.1%.

A Monitor report in September 2015 found that accident and emergency departments in England had handled the 6% average rise in accident and emergency attendances in winter 2014–15 well. But it found that pressures elsewhere in hospitals meant that accident and emergency departments struggled to move patients on to other departments. This had an impact on these data.¹⁶

Some of this has been blamed on staff shortages, although the number of accident and emergency doctors has actually increased over the past ten years. The greater challenge appears to be having the right combination of staff available at the right time, particularly consultants.¹⁷

Other factors also seem to have played a part, such as the lack of community support for patients with mental health problems who end up in emergency departments as a result;¹⁸ and the downgrading or closure at night of a number of departments.¹⁹

The bed pressure alert system (black, the most serious, when a hospital is officially overwhelmed by demand; and red when there are serious pressures) is a useful pressure gauge. A number of hospitals have been on red alert on repeated occasions in the past 12 months because of bed shortages, which in turn leads to cancelled operations,^{20, 21, 22} while others have been on black.^{23, 24} The south west of England has been particularly affected with four hospitals at times on black alerts and another three on red.^{25, 26}

The impact of service pressures on education and training

As well as the strain this puts individual doctors under, it can have serious implications for all levels of postgraduate education. For the most inexperienced doctors, those undertaking the foundation course, there is a danger that they are placed in financially challenged and stretched institutions where the service needs of the organisation may trump those of the individual and their training.

The same issue arises for more-senior doctors undertaking specialty training – here of course there will be differences by specialty, but we have evidence of education being squeezed by service pressures.²⁷ Nor is this something that just affects doctors in training – the system relies on consultants and GPs having the time to train and support – there is a need to keep a close eye on the ability of trainers to train effectively.²⁷

The growing number of hospitals that are now subject to the GMC's enhanced monitoring arrangements, up from 23 in June 2012 to 89 in September 2015, is one indication that at least some institutions are not managing the pressures adequately. Enhanced monitoring is invoked where we believe there are issues that could adversely affect patient safety, doctors' progress in training, or the quality of the training environment (see chapter 3, page 96).

Since the system was introduced in 2012, more than 120 hospitals have been included with 12 added in the first year and 32 added in 2014. While some of these additions are undoubtedly down to a greater willingness by local education bodies to report concerns, that is far from being the whole reason.

If the pressures increase further over the next few years, postgraduate medical education must be protected from the risk that doctors will find their routine work does not allow them time to continue their development. This is not just a matter for the GMC, but as the overseer of the education process, we will need to consider how we protect standards – and, if we have to intervene, when and how we should do so.

Analysing responses to the survey of doctors in training

It is, however, important that the undoubted and serious pressures are put in context. In spite of all this, the GMC's annual national training survey shows increased levels of overall satisfaction among doctors in training. Of the 53,126 doctors who took part (98% of all doctors in a training post), 88% were satisfied or very satisfied with the training they were receiving at the time of the survey. This may well be an indication that the UK's system of postgraduate training is working reasonably well but it is no cause for complacency, and it is clear from the current level of dissatisfaction around contract negotiations in England, that doctors in training have concerns about their working lives.

Moreover, behind the very positive overall figure there are some areas of concern. For example, some institutions have 'triple red flags' in certain areas. That is, for the third successive year, doctors in training have indicated that they are dissatisfied about aspects of the service or their training or both. Repeated red flags clearly suggest that the hospital or healthcare provider is not sorting out the issues.

It is important that those responsible for education at local level analyse the data from the survey closely to identify issues, down to departmental level. Often, problems are localised and understanding the intricacies of the different training environments is vital (see chapter 4). The survey has also proved useful to others – the Care Quality Commission (CQC) in England continues to use the survey as background ahead of its inspections and to match against other data. And it has proved helpful for health boards and NHS Education for Scotland – for example, the GMC training survey had pointed to concerns at Aberdeen Royal Infirmary,²⁸ which was later investigated by Health Improvement Scotland. Working with those responsible for overseeing medical education at local level, the GMC accepts that it needs to do more to make sure that health boards and trusts are aware of the data and know how to appropriately use and interpret it.²⁹

The independent Shape of Training review³⁰

concluded that patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings. This need is being driven by a growing number of people with multiple comorbidities, an ageing population, health inequalities and increasing patient expectations.

As a result, postgraduate training is being adapted to prepare medical graduates to deliver safe and effective general care in broad specialties, by giving them generic capabilities, making them more flexible in their working.

This year, we have worked with the Academy of Medical Royal Colleges (AoMRC) to consult on a proposed framework aimed at making doctors better professionals, communicators and leaders.

This framework includes the core knowledge, skills and standards of behaviour that all doctors will have to demonstrate by the end of their postgraduate specialty training, such as effective communication, teamworking and patient-centred decision making.

Transparency in healthcare

Despite numerous inquiries and unequivocal guidance on the subject, it is clear that our healthcare systems are not as transparent as they should be. Staff are not always willing to admit mistakes or to highlight failings in their colleagues or the systems in which they operate.^{31, 32} In another attempt to tackle this, the government in England has introduced a duty of candour – the change in the law came into force in April 2015, requiring all healthcare organisations to record and admit mistakes that have caused significant harm to patients as soon as possible.³³

Policy changes in this area are also being explored in Scotland, Wales and Northern Ireland.^{34, 35, 36} At the same time, eight UK professional regulators have agreed a Professional Duty of Candour,³⁷ which underlines a commitment by, and a requirement on, healthcare professionals to be open and honest with patients when things go wrong.

This also comes at a time when there are questions about how far doctors should go in disclosing medical information to outside bodies, such as the DVLA or DVA, when there are concerns that a patient's health might pose a risk to others.

New guidance on the professional duty of candour

The GMC and Nursing and Midwifery Council have published joint guidance for doctors, nurses and midwives setting out how the professional duty of candour should work in practice.³⁸

The reaction to this guidance has been very positive, but, as everyone now acknowledges, while new laws and clear guidance have an important part to play, the greatest challenges lie in creating an open and honest learning culture, in which staff feel empowered to admit mistakes and raise concerns. Compared with a generation ago, the system is much more open, but active steps by boards, managers and clinical leaders in sending the right signal will be essential if further fundamental change is going to be achieved, especially at a time when professionals and managers are under so much pressure.

Part of this will be creating a climate where staff feel more able to raise concerns. Sir Robert Francis's *Freedom to speak up* review highlighted continuing disquiet about the way organisations dealt with concerns and the treatment of some of those who have spoken up.³⁹ His solution is designed to help create the right conditions for NHS staff to speak up, and to share what works, so that all organisations are up to the standard of the best and provide redress when things go wrong.

Dealing with issues raised by whistleblowers

Ahead of the Francis review, the GMC had commissioned Sir Anthony Hooper to undertake an independent review of the way it dealt with doctors who saw themselves as whistleblowers.⁴⁰ The Hooper review reflected both on the way the GMC dealt with claims of whistleblowing and on the practices of the organisations referring concerns about the fitness to practise of these doctors to the GMC. One of the report's recommendations is that the GMC should encourage such organisations to declare whether the doctor has previously raised a concern about patient safety. In August 2015, the GMC published an action plan, exploring each of the Hooper review's recommendations, including looking further into whether doctors who are referred to fitness to practise processes are whistleblowers and how this could be taken into account when making decisions.⁴¹

There are also plans to provide training to all NHS staff in England on raising concerns.⁴²

It is too early to assess what impact the various measures will have on the way healthcare is delivered and some of the cultural changes are likely to take years rather than months to transform entrenched attitudes and behaviour.

The GMC has made clear that the key is not to frighten or threaten professionals, but to use education, management action and role models to develop a positive reaffirming culture where genuine mistakes are seen as opportunities to learn. There is a danger that action by regulators and governments will be seen as being punitive and will have the opposite effect of that intended, deterring professionals from coming forward. The GMC will work closely with governments, senior management and the profession to do what we can to help create the more open culture everyone is calling for.

Bullying and undermining in medical training

Another area where again there is now greater awareness is the bullying and undermining of members of the healthcare team. It does however continue to be a matter of real concern, with nearly one in ten doctors in training reporting that they had been bullied, while nearly one in seven said they had witnessed it in the workplace.⁴³

The GMC review, *Building a supportive environment*,⁴⁴ looked in detail at 12 hospitals where concerns had been raised through the national training survey. It focused on obstetrics and gynaecology and on surgery, as these specialties were shown to have the most issues with bullying and undermining.⁴⁵

The review found that bullying was often not malicious in intent, but a result of senior doctors being 'perfectionists' with exacting standards, which resulted in behaviour that undermined the doctors in training, both professionally and personally.⁴⁴

Whatever training stage doctors are at, they deserve to feel that they are working in a safe and supportive environment. A system where staff are frightened to raise concerns is not a safe system.

After a consultation process, the GMC has set new standards for undergraduate and postgraduate medical education and training which include an explicit requirement for organisations to provide a supportive learning environment.

The GMC also commissioned an independent report into doctors who take their own lives while under investigation – most of these doctors had pre-existing and serious mental health problems but the report suggested there were ways in which the GMC process could be improved and this has led to a fundamental review of the way we handle health related cases.⁴⁶

Revalidation three years on

Just under three years ago, the law was changed⁴⁷ to introduce a system of revalidation for all doctors practising in the UK. It is one of the most ambitious and comprehensive schemes in the world and is subject to a number of evaluations.⁴⁸ In some ways it is too early to reach any definitive conclusions about the impact of a single but intricate intervention into such a complex system. But there are a number of encouraging signs.

Positive outcomes of revalidation so far

First, it does appear to have been introduced and to be operating smoothly throughout the UK and in all sectors. Inevitably, there are small numbers of doctors who have found it more difficult to find their way through the system, but for the vast majority the process, based on employer appraisal, has worked.

As of September 2015, more than 110,000 doctors on the register have been revalidated, leaving 37,014 to be approved by April 2016, when we expect most to have completed the first cycle.

The reactions from Responsible Officers, the senior doctors running the system within organisations, have been overwhelmingly positive, with many reports that the process has introduced rigour and tangible improvements in clinical governance.

Secondly, it is clear that the introduction of revalidation has brought about significant improvements in appraisal rates throughout the UK healthcare systems. It is especially encouraging, for example, that staff grade and locum doctors, who in the past have been neglected by too many employers, are now starting to have their practice appraised, and are being given access to data about their practice and are being given feedback from patients, colleagues and their employer.

Thirdly, the process is having a direct impact on various aspects of practice. Between 2012 and 2014, 13,948 more doctors chose not to continue to hold a licence to practise. Between 2010 and 2012, the increase in the number of doctors who did not hold a licence to practise was just 3,727.

Many of these doctors were over 70 years old or lived overseas, and were not in a position to practise in the UK. But some of the increase will be down to doctors who did not want to participate in having their practice checked, and it must be welcome that these doctors are no longer treating patients. At the same time, around 2 million patients have taken part in the process by giving feedback about their doctor – a very significant move in terms of patient involvement.

Finally, while the rate of deferral of revalidation recommendations may look relatively high at 18%, this includes a large number of doctors in training whose date has to be moved for technical reasons. For the remainder, the reasons are mostly to do with personal circumstances, such as sickness or absence for maternity leave. But it also includes 1,047 doctors who are subject to local processes of investigation and remediation, and the GMC itself has put revalidation on hold for some doctors within its procedures.

Developing revalidation

The GMC is committed to working with the profession, the four governments of the UK, patient groups and others with an interest in this work to develop revalidation – above all, it is a patient safety initiative designed to provide assurance about the competence of doctors and to encourage reflective practice. We all need to learn the lessons of this first cycle and adapt the model accordingly – we should seek to make sure that doctors are not overburdened with regulatory requirements, that doctors are not required to provide information more than once and that everything that is asked for is needed for that specific purpose. Overall, the first few years have certainly been encouraging.

A mobile, globally-sourced profession

This year's report gives an update on where doctors now practising in the UK have come from. Medicine is an increasingly mobile profession and that is posing challenges for jurisdictions all over the world. The UK must not only make sure that its own graduates meet the required standards, but that all doctors coming to practise here have been evaluated to the same high level.

At present, graduates from medical schools within the European Economic Area (EEA) have freedom of movement to work in the UK. This means that the GMC has no means of checking that these doctors meet the standards we set for international medical graduates from other parts of the world or indeed the standards required of UK graduates. As we have made clear on a number of occasions, this represents a major weakness in the UK regulatory system.

In 1975 the *Recognition of professional qualifications directive* (the Directive) established minimum training requirements for doctors qualifications. Doctors whose qualifications meet these requirements are entitled to have them recognised in all EEA countries. Amendments to the Directive were made in 2013 and will come into force in January 2016. Following an extensive engagement campaign with UK Government, UK and European regulators, MEPs and the EU institutions, the GMC was successful in ensuring the amendments to the Directive included many positive aspects supporting high standards of medical education and training including the introduction of a fitness to practise alert mechanism between countries, and stronger and clearer language checking powers.

In addition to this, in June 2014, the UK passed a law that enabled the GMC to check whether European doctors have the necessary English language skills before granting them a licence to practise. In this first year of operation, the result has been that more than 500 doctors were not given a licence because they were not able to provide more evidence of their English language proficiency.

This is an important improvement but it still leaves the issue of the competency of European doctors who come to work in the UK.

At the same time, an independent review of the GMC's Professional and Linguistic Assessments Board (PLAB) examination contained a number of recommendations to strengthen this test for international medical graduates, which are now being implemented.⁴⁹

Continuing emphasis on patient safety

Of even greater significance, the GMC's council has approved a plan to develop a new unified assessment, the UK Medical Licensing Assessment (UKMLA), for doctors seeking to practise in the UK. This would replace the current PLAB test and would also be taken by UK graduates who come from a variety of medical schools and do not currently sit a UK licensing assessment.

The aim is to create a straightforward and transparent route to medical practice in the UK. There are challenges, including how best to protect patient safety when EEA doctors exercise their legal right to enter practice in the UK. But we are determined to work with all those with an interest in this area to create an assessment that will help to drive up standards and become an international benchmark of excellence for entry to medicine.

Strengthening mechanisms to protect patients

During 2014–15, there have been continuing efforts to make patient safety a defining characteristic of the UK health system. The Scottish Patient Safety Programme (SPSP) has already delivered significant results and has now gone beyond acute hospitals, to cover maternity, mental health, and primary care.⁵⁰ The creation in England of the Independent Patient Safety Investigation Service reflects a commitment to develop a low-blame culture, which should help to expose the underlying reasons behind major patient safety failures.⁵¹

Doctors have been leading this movement. And while there have been major strides, the conclusion reached by Professor Don Berwick in his 2013 report *A promise to learn – a commitment to act* that patient safety problems exist throughout the NHS remains valid today.⁵² Professional regulation can only ever be one part of this but it should be seen as an important contributor and the GMC certainly sees itself first and foremost as a patient safety organisation.

If safety is to play a more central role, it needs to be fully integrated into undergraduate and postgraduate education as well as being at the forefront of a doctors' working life once training has been completed. Initial steps are being taken jointly by the GMC and the Medical Schools Council to highlight and promote good practice, as set out in the recent report *First, do no harm: enhancing patient safety teaching in undergraduate medical education*.⁵³

The new standards for postgraduate medical education and training make clear that local education providers – hospitals and other institutions where training takes place – are expected to take responsibility for ensuring that doctors in training are appropriately supervised. And that their responsibilities, related duties, working hours and supervision are consistent with the delivery of high-quality, safe patient care.⁵⁴

The aim of this year's report

Since the first edition of this report in 2011, the aim has been to share data and research and highlight pressing issues that affect the education and practice of doctors in the UK.

Every year, we have sought to develop the data and the analysis and where possible to correlate them with others. We hope this report will be relevant and helpful to the profession, the medical education community and the wider health system.

What we look at in each chapter

Chapter 1 looks in detail at doctors with a licence to practise in the UK and the flow of these doctors into and out of the profession. It also sets out the demographic make-up of doctors in different specialty groups, and the countries from which doctors are increasingly coming to work here – as well as the countries that are supplying fewer doctors. It also looks at regional variation within the UK.

Chapter 2 focuses on the GMC's fitness to practise data and where complaints about doctors come from, which complainants bring which cases before the GMC, and whether different combinations of complaints and complainants are more or less likely to result in a warning or sanction. We also consider what can affect the length of a fitness to practise case.

In **chapter 3** we use data from across the GMC to examine those issues about which doctors have sought guidance as well as issues that have been reported to the GMC where standards of care have not reached acceptable levels and intervention may be required. This chapter also looks at themes in the fitness to practise cases that lead to the most serious sanctions of erasure and suspension, and the importance of issues such as honesty in these cases.

Chapter 4 considers how the risk of poor professional performance by doctors may relate to where they work and examines whether there is a meaningful correlation between interventions such as the imposition of special measures, CQC inspection results and fitness to practise investigations. We also look at how the views of doctors in training can inform governance at departmental level.

Chapter 5 looks at current knowledge on the variability in progression through medical education among doctors and specifically those from black and minority ethnic backgrounds, and how gaps in attainment could be addressed.

Finally, **chapter 6** studies the effects of sanctions and warnings on doctors involved in GMC fitness to practise processes in terms of their ability to remediate and return to full professional standards. This explores how employers' support can be critical to doctors being able to remediate after they have breached standards.

These chapters are all very different but share a common aim: to further our understanding of how doctors can be supported to achieve and maintain good medical practice in order to safeguard patient safety and care; and to discover how we can reduce the risk of that practice falling short and prevent barriers to remediation when practice is impaired.

As we hope this report attests, the GMC itself is changing and part of that is learning how to use and share data in ways that will help to identify risks and trends, rather than simply intervening when things have gone wrong. Our new Chair Professor Terence Stephenson has underlined our key role as a patient safety organisation and the need for us to work even more closely with others as we continue our own major programme of reform. That will protect patients and help to improve medical practice in the UK.

We believe that the future of medical regulation lies in greater engagement with patients, doctors, employers and others. This report is part of that engagement, and as ever we welcome feedback and any further insights which can be made by others.



Niall Dickson
Chief Executive and Registrar, GMC

Executive summary

This is the fifth annual report on the state of medical education and practice in the UK. It focuses on what recent data and analysis can contribute our understanding of the challenges and risks that the medical profession faces.

The UK medical profession is rightly held in high esteem worldwide. Concerns about professional standards relate to a small minority of doctors. Nevertheless, the ambition must be both to improve standards generally and, as far as possible, to understand and remove any risks to the safety of patients.

This report includes:

- discussions about the subjects doctors seek further guidance on to prevent breaching standards
- an examination of the relationship between the places where doctors work and their professional standards

- attainment in medical education
- an examination of the types of case in which there has been a severe breach of standards requiring the suspension or removal of the doctor's licence to practise
- a study of the obstacles to the remediation of poor standards.

Along with this year's report, we have also published an extensive online resource of the GMC's registration, education and fitness to practise data. This contains more than 1,000 tables, set out in a structure designed to make it easy to find key figures. We hope that patient groups, employers, doctors, workforce planners, policymakers, researchers and regulators find this resource useful, together with the analysis in this year's report.

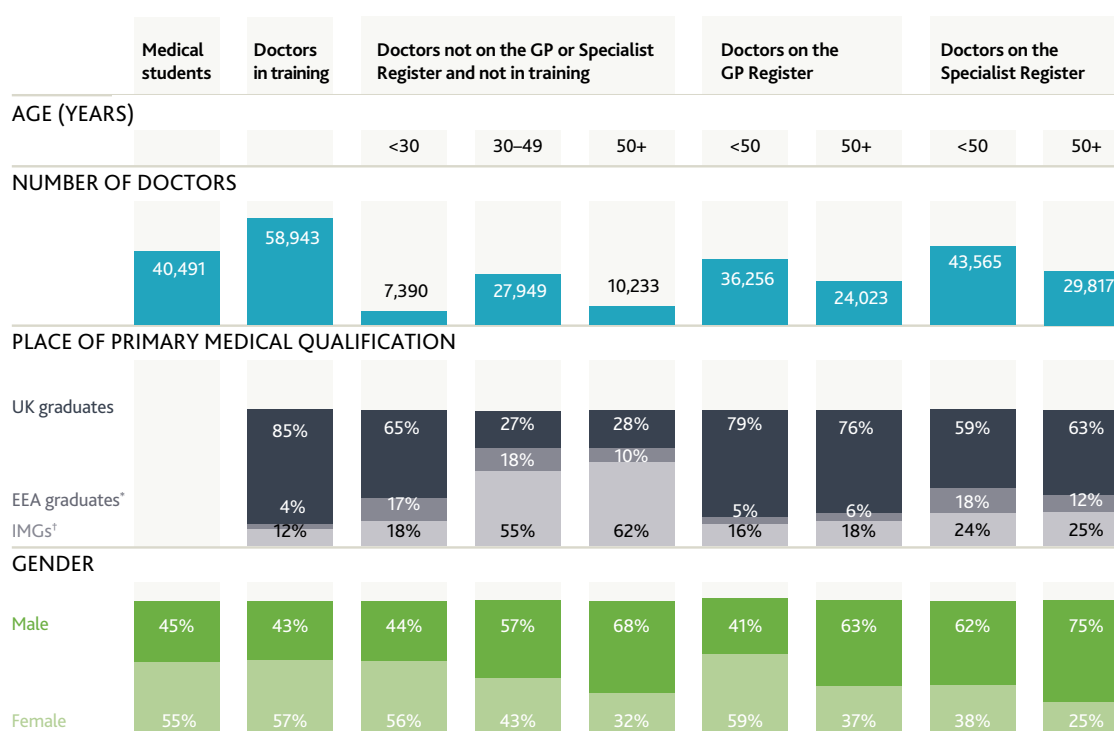
Our data on doctors working and training in the UK (Chapter one)

In 2014, there were 267,168 doctors on the UK medical register, 236,908 of whom had a licence to practise in the UK. Figure 3 (page 31) sets out the size of the medical workforce and some characteristics of licensed doctors and medical students in the UK. As previously reported, the proportion of female doctors continues to increase: in 2014 female doctors make up just over 50% of the GP Register for the first time.

We have identified areas of concern in the make-up of the profession in some specialties, which could have an impact in the future.

- A high, or increasing, reliance on older doctors.
- A high, or increasing, reliance on non-UK graduates.

Figure 1: Demographic characteristics of licensed doctors on the register and medical students in 2014



* EEA graduates are doctors who gained their primary medical qualification in the EEA, but outside the UK, and who are EEA nationals or have European Community rights to be treated as EEA nationals.

† IMGs are doctors who gained their primary medical qualification outside the UK, EEA and Switzerland and who do not have European Community rights to work in the UK.

A growing number of licensed doctors

The medical register continues to grow – since 2010, the number of registered doctors has grown by 12%. The number of licensed doctors has grown a little more slowly, by 4.5%, coinciding in part with the introduction of revalidation that encouraged some to choose not to continue to hold a licence to practise.

The number of doctors from southern Europe is increasing

The number of doctors from countries with high unemployment rates – such as Greece, Italy, Portugal and Spain – has increased by almost 2,107 during 2011–13, an increase of 36%.

Fewer doctors from many other parts of the world are taking up a UK licence to practise, and more are giving them up. The largest decrease in doctors on the register was among those who graduated in South Africa and India.

Pathology, intensive care and surgery rely on older doctors

Some specialty groups have an increasing proportion of older doctors – including intensive care and surgery. Pathology relies heavily on older doctors, and that specialty may risk not being replenished with younger doctors.

Some specialties are particularly reliant on non-UK graduates

Certain specialties rely more heavily on non-UK graduates, who are increasingly giving up their UK licence to practise, either to retire or to work abroad. In 2014, the majority of doctors in the obstetrics and gynaecology specialty were non-UK graduates, as were almost half of ophthalmology doctors.

Compared with the rest of the register, medicine, psychiatry, paediatrics, pathology, ophthalmology and emergency medicine saw substantially greater increases in the number of non-UK graduates during 2010–14. These specialties might be more at risk of doctors retiring or leaving in the future.

Complaints to the GMC about doctors (Chapter two)

Chapter 2 analyses complaints that were made to the GMC about doctors. The analysis focuses on two areas.

- The outcomes from different types of complaint.
- Who is making complaints and what sort of complaints they make.

Figure 2: Proportion of male and female doctors who were complained about, had the complaint investigated and received a sanction or a warning during 2012–14

	Doctors in training	Doctors not on the GP or Specialist Register and not in training			Doctors on the GP Register		Doctors on the Specialist Register	
AGE (YEARS)		<30	30–49	50+	<50	50+	<50	50+
MALE DOCTORS COMPLAINED ABOUT								
Not complained about	98%	96%	94%	90%	86%	80%	91%	86%
Complained about	2%	4%	6%	10%	14%	20%	9%	14%
RESULT OF COMPLAINT								
Closed immediately or referred back to employer	45%	35%	36%	46%	68%	65%	63%	64%
Investigated then closed without a sanction or a warning	44%	48%	52%	47%	29%	32%	33%	33%
Investigated then closed with a sanction or a warning	11%	17%	12%	7%	3%	3%	3%	3%
FEMALE DOCTORS COMPLAINED ABOUT								
Not complained about	98%	98%	97%	95%	93%	88%	95%	92%
Complained about	2%	2%	3%	5%	7%	12%	5%	8%
RESULT OF COMPLAINT								
Closed immediately or referred back to employer	57%	43%	44%	48%	74%	70%	68%	72%
Investigated then closed without a sanction or a warning	36%	44%	43%	47%	25%	28%	29%	27%
Investigated then closed with a sanction or a warning	7%	13%	14%	5%	2%	2%	3%	1%

The number of concerns raised by doctors has doubled in four years

The number of complaints that doctors (not acting on behalf of their employer) made about doctors nearly doubled from 654 in 2010 to 1,277 in 2014.

Unsurprisingly, most complaints still come from members of the public – the number increased from 3,858 in 2010 to 5,808 in 2014. Overall, the total number of complaints rose by 54% over the four years to 2014, but the increase slowed sharply in 2013 and 2014, increasing by only 5% in 2013, and falling by 2% in 2014.

The number of complaints closed with no action has increased much faster than the number resulting in a sanction

The number of complaints closed with no further action more than doubled between 2010 and 2014. In contrast to the number of complaints closed without a sanction, the number of sanctions decreased by 7% from 512 in 2010 to 479 in 2014. Some of these trends are driven by changes in how the GMC handles complaints, and some are informing the GMC's ongoing programme of reform to improve fitness to practise processes.

Hardly any investigations of clinical competence stemming from complaints by the public lead to a sanction or a warning

Nearly a third (31%) of cases from complaints made by members of the public are solely about the clinical competence of doctors. But 92% of these result in no sanction or warning, in part because in these cases it is more likely that a doctor can prove remediation and demonstrate insight in their cases.

Men face more investigations than women

Men are significantly more likely to face investigations than women, especially in criminality cases. Overall, 75% of investigations were about men and 82% of criminality investigations were against men.

BME and non-UK doctors are overrepresented in investigations

Between 2010 and 2014, a higher proportion of doctors who graduated outside the UK were subject to GMC investigations (59 per 1,000 doctors) than was the case for UK graduates (38 per 1,000 doctors).

Because doctors from a black and ethnic minority (BME) background account for a high proportion of non-UK doctors (66%), this also translates into a higher proportion of BME doctors being subject to GMC investigations in this period (55 per 1,000 doctors). BME doctors who were UK graduates were subject to a slightly higher proportion of GMC investigations than white UK graduates (41 per 1,000 doctors compared with 35 per 1,000).

Employers and others acting in a public capacity were more likely than individual doctors or the public to refer non-UK graduates. 63% of investigations stemming from concerns raised by employers and 52% of those stemming from others acting in a public capacity were about non-UK graduates. This compares with only 38% of investigations arising from concerns raised by doctors and 38% of those arising from complaints made by the public. This pattern was evident for all types of concerns and complaints, apart from ones about a doctor's health.

Issues linked to professional standards (Chapter three)

This chapter gives an analysis of education data and feedback received from medical educators, and from front-line doctors engaging with GMC liaison teams and contacting the confidential helpline. It also examines the fitness to practise cases that led to the doctor being suspended or removed from the register.

Medical educators raise a number of concerns with the GMC

Medical royal colleges and faculties submit an annual report to the GMC about their specialities, which gives an important insight into how different branches of the profession are managing – particularly in terms of education and training. This year, the reports highlight a number of concerns including concerns that the transfer of services to the independent sector is affecting training quality, and that difficulties filling posts is affecting the training quality of junior doctors.

Hospitals and other health providers that are subject to enhanced monitoring of their undergraduate and postgraduate training

During 2014, training environments in 28 NHS bodies were placed under enhanced monitoring. The most commonly reported concerns focused on poor access to education and problems with clinical supervision both on weekdays and at nights and weekends. In three of the trusts under enhanced monitoring, allegations of bullying or undermining of doctors in training were serious enough to require direct GMC intervention.

Areas where doctors are seeking advice to maintain standards

There are certain issues where doctors are coming forward to enquire about aspects of their practice. The principal areas are prescribing, confidentiality, the impact of new technology, and end of life care.

It is possible that these areas may be of more widespread concern within the profession and that there is a need to raise the profile of the issue or consider more guidance.

The most serious breaches of standards involve dishonesty, inappropriate relationships at work and inappropriate personal behaviour

A small study for this year's report looked at fitness to practise investigations that resulted in the most serious sanctions – suspension or removal from the medical register.

The study found that about half of these cases were predominantly about dishonesty, in one form or another. Sometimes, there was also a criminal conviction. Other themes include inappropriate behaviour and relationships both with patients and in the workplace.

GMC data and the performance of an organisation: a case study on acute trusts in England (Chapter four)

This study of acute trusts in England looked at whether the risk of a doctor at the trust being involved in a GMC investigation or the views of doctors in training in the GMC annual National Training Survey were in any way related to a trust being put into special measures or to the ratings given by the Care Quality Commission (CQC) to that trust.

The overall rating given by the CQC to providers is often worse when trusts have more doctors going through a fitness to practise investigation. The CQC operates a four-point scale from inadequate through to outstanding. There are around ten additional investigations per 1,000 doctors for each step down the rating scale, with those rated inadequate therefore likely to have 40 more investigations per 1,000 doctors than those rated as outstanding.

Hospital trusts in special measures have more fitness to practise complaints, but this may simply indicate heightened vigilance. The vast majority of this increase comes from institutional referrals within the trust. Interestingly, it does not lead to corresponding levels of sanctions and warnings, suggesting the increased vigilance in terms of referrals to the GMC may not in practice reflect more doctors in serious difficulty.

The study shows that there is a comparative increase in fitness to practise complaints and investigations in acute trusts in England one to two years before they were put into special measures. There is also a fall in complaints in the year after. It is important to note, however, that there is wide variety between individual trusts in the year they go into special measures and subsequent years. A trust going into special measures is unlikely therefore to be a useful predictor of fitness to practise activity.

Doctors' overall satisfaction with their training environment and clinical supervision declined during the year a trust went into special measures, but not thereafter.

Satisfaction with their training posts is higher in providers rated as outstanding by the CQC in England than those rated inadequate, but there is such a wide range in satisfaction for providers between these extremes that this indicator cannot be used as a predictive measure when extrapolated up to trust level.

Understanding differences in educational attainment (Chapter five)

This chapter looks at current knowledge and new research on variability in progression through medical education in the UK. It looks at differences depending on the doctor's ethnicity and where they first qualified.

An ethnic gap in average attainment at medical school persists

There is an attainment gap in medical school exams between different ethnic groups, even after accounting for demographic and parental factors, age, learning styles, living at home, first language and prior education.⁵⁵

This year the GMC collected and analysed data across all specialties. The data show lower attainment of BME doctors and non-UK graduates is fairly consistent across all specialties.

- BME UK graduates were more likely (72%) than white EEAs (53%) or IMGs (49%) to get an offer of a post in the first specialty (core) recruitment round, and to pass their exams.
- UK graduates passed their postgraduate exams* over 70% of the time, whereas EEA graduates and IMGs passed less than 50% of the time.

- BME UK graduates were less likely to get an offer of a post in the first recruitment round for those in foundation training applying to Level 1 (L1) training than white UK graduates (72% vs 81%) and less likely to pass their exams, once in training (64% vs 76%).

Identifying doctors training to be GPs who are less likely to do well in their final exams

New independent research shows that trainees doing less well in final GP exams are more likely also to have done less well in the assessments done on entering GP training. It is therefore possible to identify at the outset doctors in GP training who are less likely to do well in their final exams. It is important that appropriate support is made available to these trainees.

At this stage we don't know to what extent these findings apply to other specialties. The GMC is carrying out a comprehensive analysis of exam performance, recruitment and other outcomes that should help to answer this question.

* This includes all attempts, not only the first attempt to pass postgraduate medical exams. Exams data currently only cover one year.

Upholding standards and the remediation of doctors (Chapter six)

This chapter reports on a small study commissioned by the GMC for this report. It surveyed 99 doctors who received warnings or restrictions on their practice between 2006 and 2014, and interviewed 38 doctors and 20 employers in depth. The aim was to try to reach a better understanding of the impact of the warning or restrictions and how this impact has shaped their remediation or development as a doctor.

Successful remediation depends on the attitudes of both doctors and employers

Remediation often depends on both the doctor and their employer being willing and able to make it happen. The doctor has to have the insight to change, and the employer has to be willing to give them adequate support.

Remediation tends to be less successful where doctors perceive the process to have been unfair or where employers do not want to support the doctor or are not able to resource that support. In such cases, doctors report that the warning or restrictions on their practice have had serious consequences for their career.

The extent to which employers are willing to support the doctor varies depending on a wide range of factors. These include their prior experience with the doctor, the resources available, the perceived value of the doctor concerned, the position and attitude of the doctor, the subject and nature of the sanction or warning, whether the employer empathises with the doctor's predicament, and the reputational risk to the organisation.

Improving the potential for remediation

The law is clear – responsibility for remediating lies with the individual doctor. However, in many cases doctors say that, in spite of their best efforts, they are unable to make arrangements that conform with the restrictions that have been imposed by the GMC to ensure patients remain safe.

More successful remediation could be encouraged by a number of interventions. The GMC is currently considering the extent to which it is possible to do the following while keeping patients safe:

- tailor the practicalities of restrictions more to the specific circumstances of both the doctor and employer
- improve dialogue between the doctor and the GMC during the fitness to practise processes (some reforms in this area have already begun)
- publicise more effectively what the warnings and restrictions on practice are and what they are there for.

Creating a more sophisticated range of warnings in terms of length and type tailored to the nature of the concern may also improve remediation. The GMC is considering possibilities in this respect following consultation on the indicative sanctions guidance for warnings.

Resourcing remediation

There is a need for a wider debate about whether and how far society wants to bear the costs of effective remediation of doctors who find themselves unable to practise safely and effectively without restrictions. Some will argue that it has largely to be a matter for the individual to remedy the situation themselves; others point to the opportunities for improved care that reflection and remediation offer, the welfare of the doctors concerned, current resource pressures in the NHS and the financial implications of losing doctors halfway through their career. If the answer is that enabling effective remediation is desirable, a decision will need to be made about who is responsible for resourcing and facilitating it.

Chapter one: Our data on doctors working in the UK

Who are the doctors on the medical register?

In 2014, there were 267,168 doctors on the UK medical register. This chapter gives an overview of the numbers of doctors in training, general practitioners (GPs), specialists and others on the medical register (figure 3, page 31). In particular, it focuses on the 236,908 doctors with a licence to practise. We look at their age and whether they were graduates of UK medical schools, graduates from the rest of the European Economic Area (EEA)* or international medical graduates (IMGs)† from other parts of the world.†

We also highlight some of the patterns within the groups of doctors, such as the number gaining or giving up their licence, and why these doctors are choosing to stop practising, for example because they are retiring or moving to practise abroad.

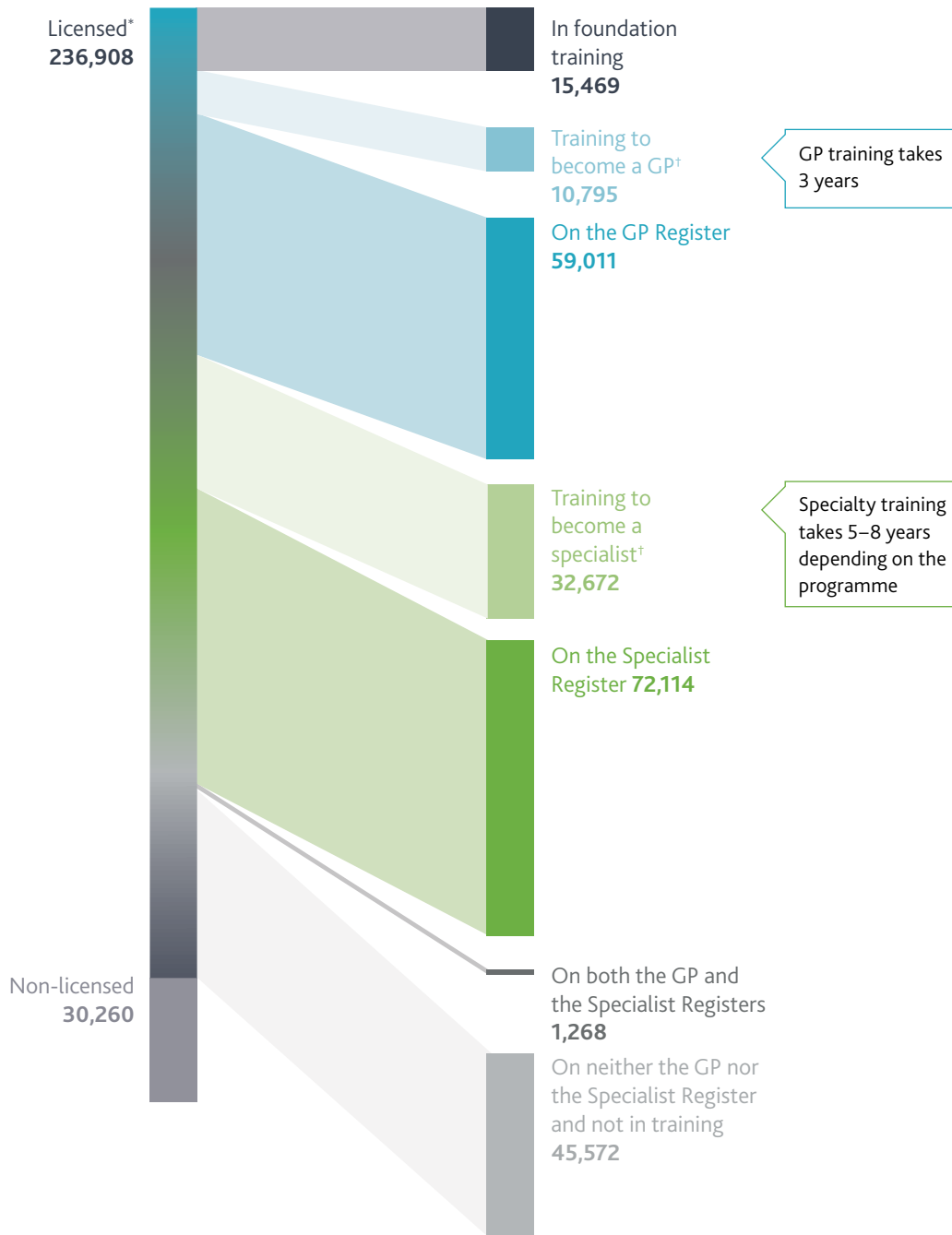
This year's report considers how the make-up of the medical workforce will develop, and the policy implications of this changing profession.

* EEA graduates are doctors who gained their primary medical qualification in the EEA, but outside the UK, and who are EEA nationals or have European Community rights to be treated as EEA nationals.

† IMGs are doctors who gained their primary medical qualification outside the UK, EEA and Switzerland and who do not have European Community rights to work in the UK.

Figure 3: Doctors on the medical register in 2014

Total number of doctors **267,168**



* A total of 7 licensed doctors were not categorised in the column to the right due to data samples being taken at a different time.

† For doctors in broad based training that can lead to a range of specialties – such as acute care common stem (ACCS) or broad based training – we allocated them to 'Training to become a GP' or to 'Training to become a specialist' depending on the number of training posts available to them. Where that was not possible, we allocated the doctors in proportion to the different specialties that the broad training leads to.

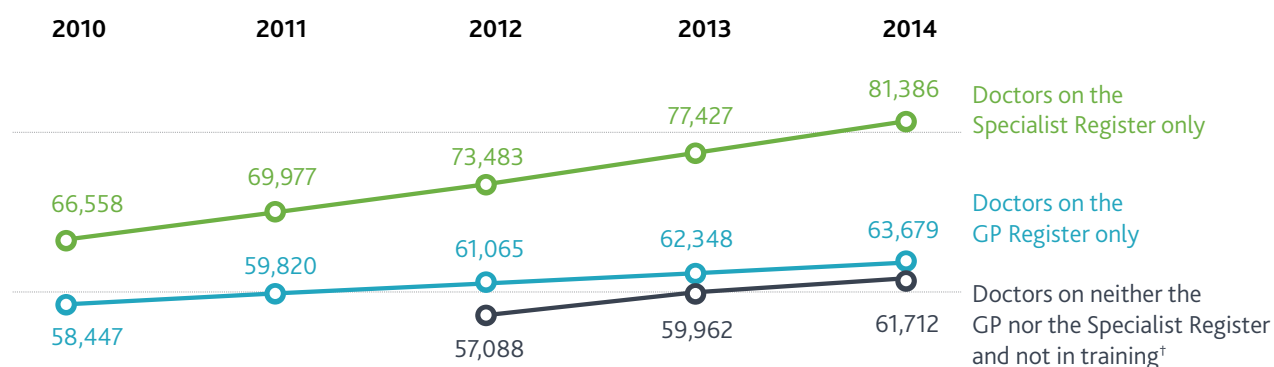
The number of doctors on all registers has grown since 2010

The total number of all doctors on the medical register in the UK has risen by 12% since 2010 (figure 4).

Over the past five years, the number of doctors on the Specialist Register has grown by 22%.

The number of GPs has risen less sharply, by just 9%. There are more than three times as many doctors training to be specialists (32,672) than GP trainees (10,795) but as specialty training takes longer a greater number of doctors in specialty training would be expected even if the annual outturn was the same.

Figure 4: Number of doctors on the medical register,* including non-licensed doctors, during 2010–14



* Doctors who are on both the Specialist and the GP Registers are not counted in this figure.

† The number of doctors not on the GP or Specialist Register or in training is available from 2012 onwards, when the national training survey was updated.

During 2010–14, there was a substantial growth in the number of non-licensed doctors on the register (figure 5). There was a particularly large increase (24% or 3,180) in 2011–12 and an even bigger increase in 2013–14 (41% or 8,859; figure 6, page 34).

This coincided with the introduction of revalidation in December 2012 for all doctors practising in the UK. Doctors now have the opportunity to decide

whether they need to retain their licence for the work that they do. Some doctors work in research or teaching roles, where they are not practising medicine and do not need a licence to practise. Many doctors who have given up their licence to practise have chosen to maintain their registration, which maintains their connection with the profession and enables them to state their good standing with their regulator.

Figure 5: Number of non-licensed doctors on the medical register during 2010–14

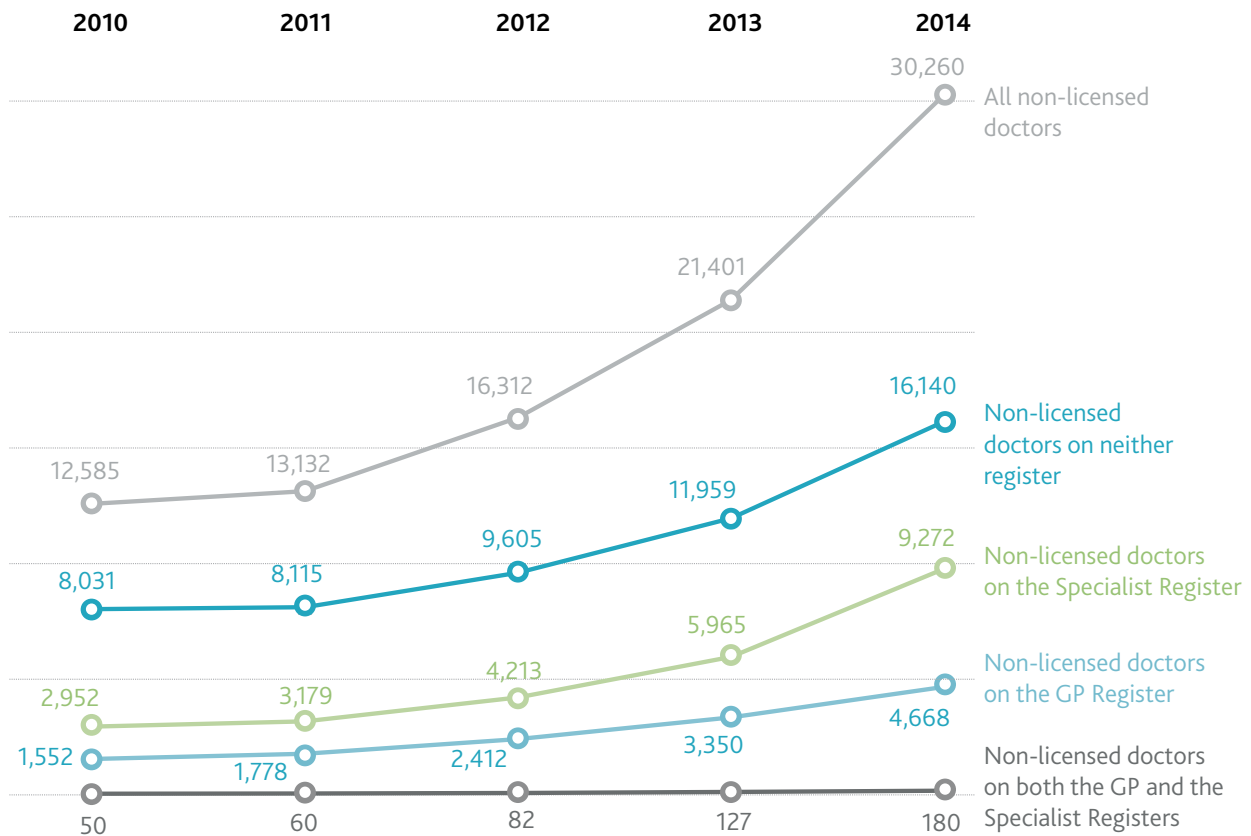
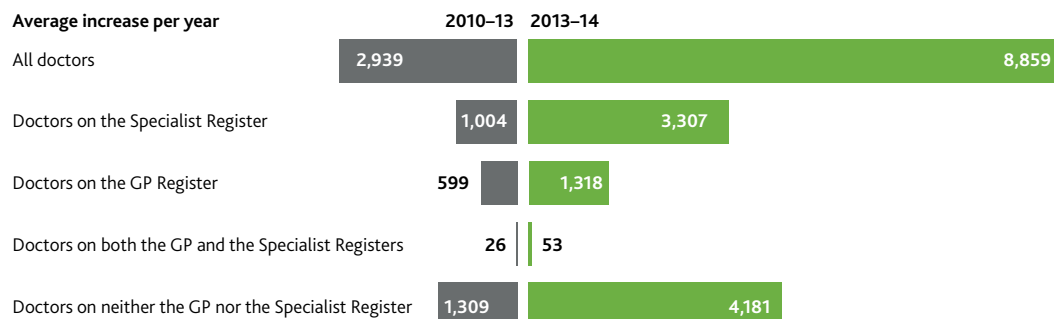


Figure 6: The average annual increase in the different types of non-licensed doctors



An increase in non-licensed doctors was common across all age groups, but was larger for doctors who gained their primary medical qualification outside the UK, particularly from the EEA (figure 7).

Figure 7: Changes in the demographic characteristics of non-licensed doctors from 2013-2014



Revalidation

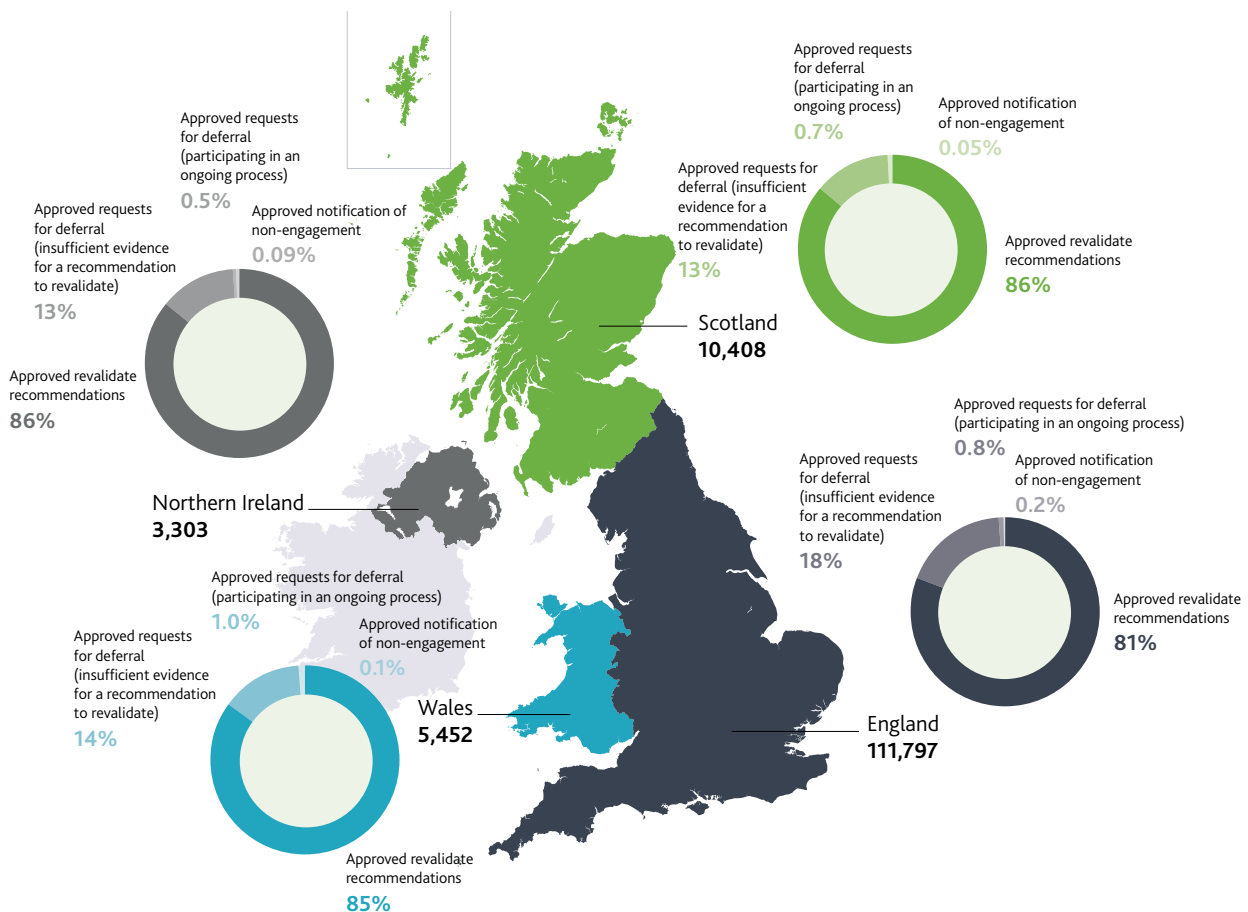
In the UK revalidation was introduced in December 2012. This requires all licensed doctors to demonstrate they are keeping their skills and knowledge up to date. All doctors are expected to undergo an appraisal or check every year, and every five years their Responsible Officer will recommend to the GMC that the doctor is revalidated, or that the decision is deferred while they gather further evidence or resolve local processes, or that the doctor has failed to engage.

Deferring the decision is a neutral act that has no effect on a doctor’s licence to practise, and gives the doctor more time to gather and present supporting evidence that they have met the required standards to revalidate.

A wide range of circumstances can lead to a deferral, such as a temporary break from work for health reasons.

As of 30 June 2015, the GMC had received 130,960 recommendations about a doctor’s revalidation, from a total of 207,108 doctors connected to a Responsible Officer. In addition, 1,624 doctors had had their licences to practise withdrawn for failing to engage with revalidation. In many cases these doctors were living overseas and did not need a UK licence to practise or were older and may well have retired from active practice. However, in order to protect patients, the fact that these doctors could not or chose not to demonstrate that they could meet the standards required has meant that they are no longer allowed to practise, in the UK.

Figure 8: Revalidation recommendations received



Foundation training

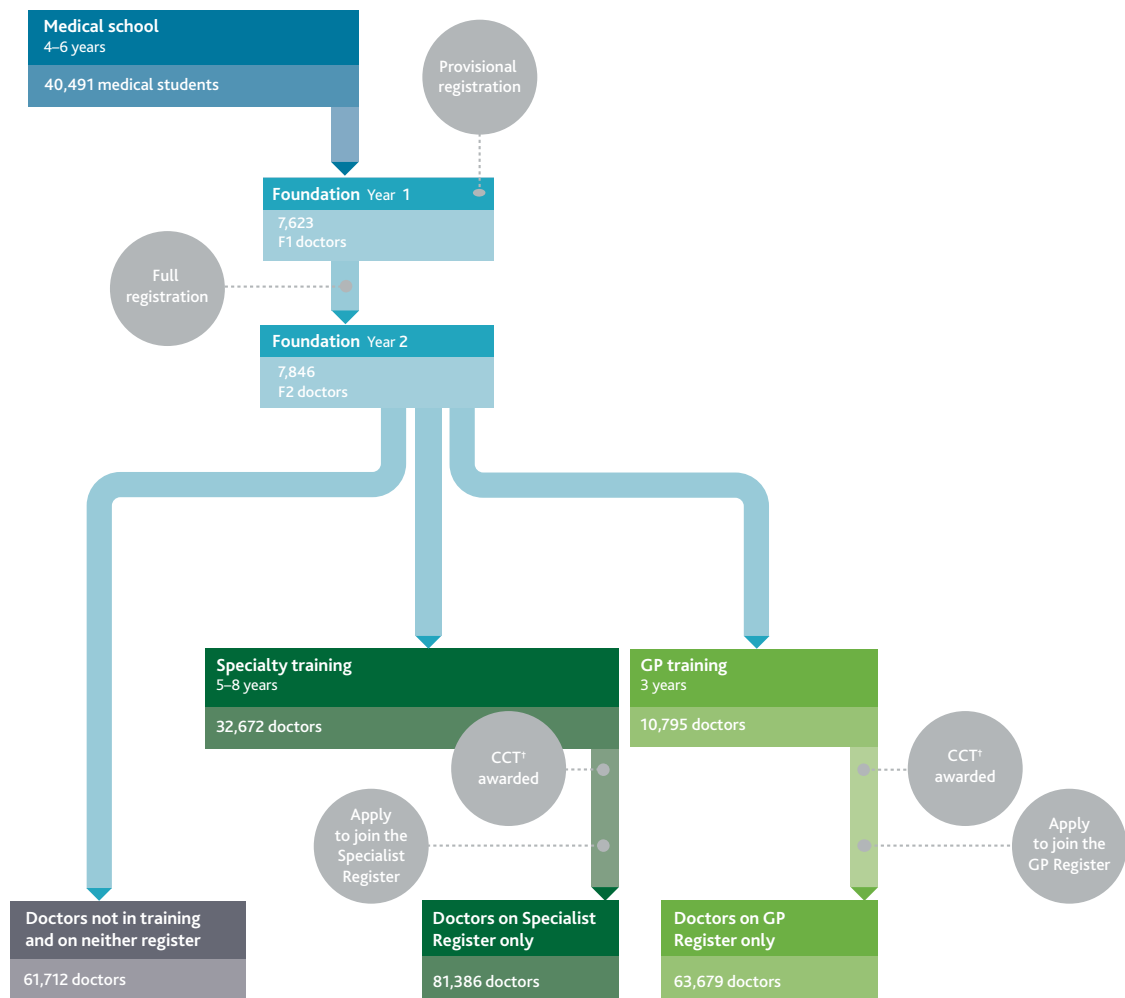
2–3% of Foundation Year 1 doctors do not progress to the next stage

After graduating from medical school, doctors start two years of foundation training. In their first year of foundation training (F1), doctors are provisionally registered with a licence to practise, and can apply for full registration when they complete that first year. For a variety of reasons a small proportion of these doctors do not make it to the second year of foundation training (F2).

In August 2014, 174 (2.3%) of 7,547 F1 doctors were not signed off and were therefore not admitted to full registration.⁵⁶

After two years of foundation training, doctors who continue to train in the UK can either go into GP training or specialist training or practise as a doctor without further training (figure 9). At each stage – foundation training, GP training and specialty training – non-UK graduates also join the training programmes.

Figure 9: The stages of medical education*



* Doctors who are on both the Specialist and the GP Registers are not counted in this figure.

† Certificates of Completion of Training (CCT).

The number of European Economic Area graduates and International Medical Graduates in foundation training is decreasing

Figure 10 (page 38) shows where F1 and F2 doctors were awarded their primary medical qualification in 2014 and how old they were.

UK graduates dominate: 7,462 (98%) were in F1 and 7,450 in F2 (95%), of whom the vast majority were under 30 (92% in F1 and 90% in F2).

Recent changes to UK immigration laws have affected the ability of some overseas graduates to undertake postgraduate training in the UK. However, it is not clear from the data whether this accounts for the difference between the number of IMGs in F1 and F2 in 2014. Most EEA graduates are unlikely to be affected by UK immigration laws.

However, only EEA doctors from countries whose graduates are eligible for provisional registration in the UK can apply for F1, whereas all fully registered doctors from the EEA can apply for F2.

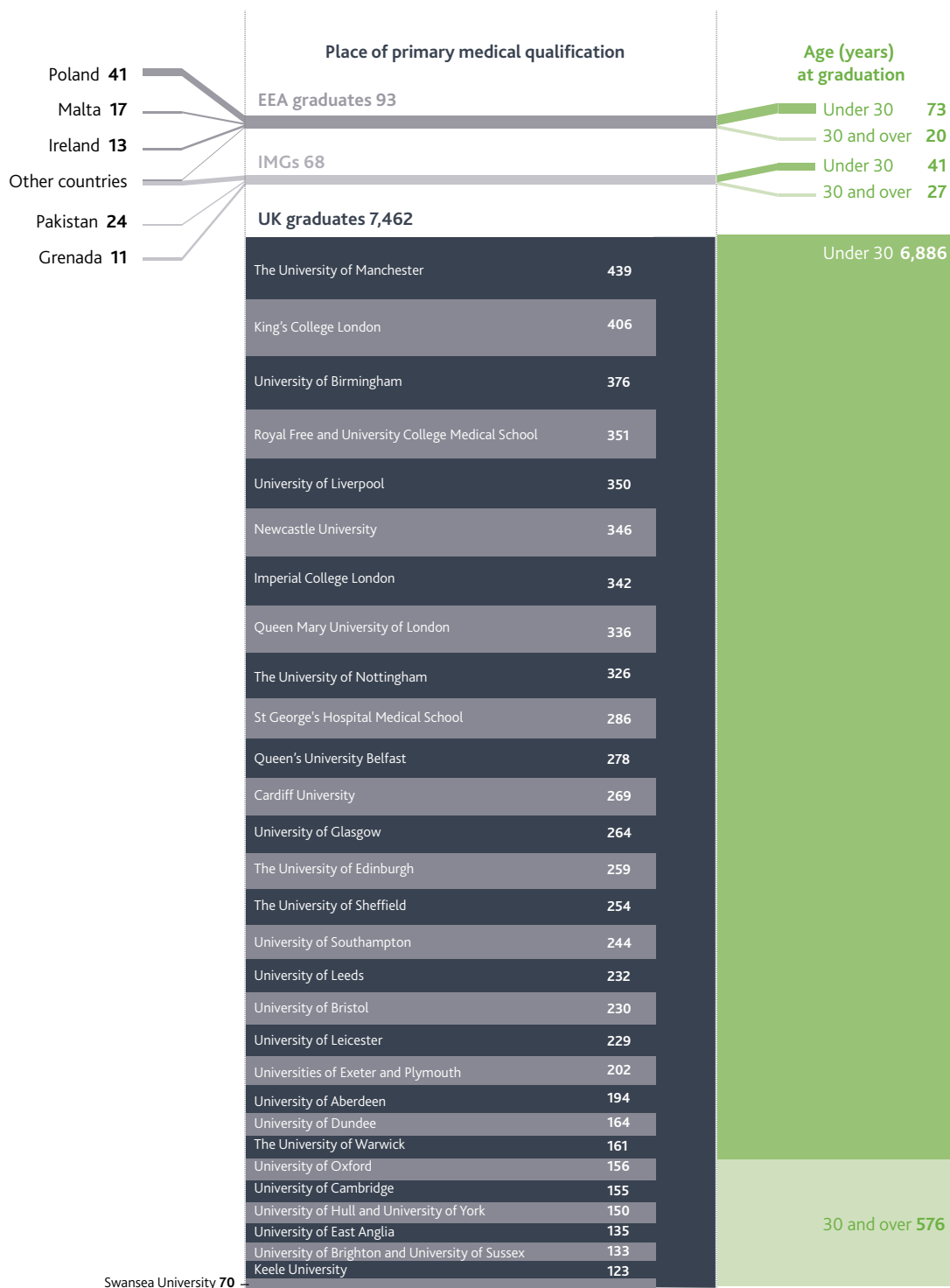
There were 185 EEA graduates in F2, but only 93 in F1, and there were 211 IMGs in F2, but only 68 in F1. A higher proportion of EEA graduates and IMGs in foundation training are over 30 years old compared with UK graduates: 22% of EEA graduates in F1 and 28% in F2, and 40% of IMGs in F1 and 47% in F2.

Non-UK graduates and older doctors have higher rates of fitness to practise complaints than the general population of doctors.⁵⁷

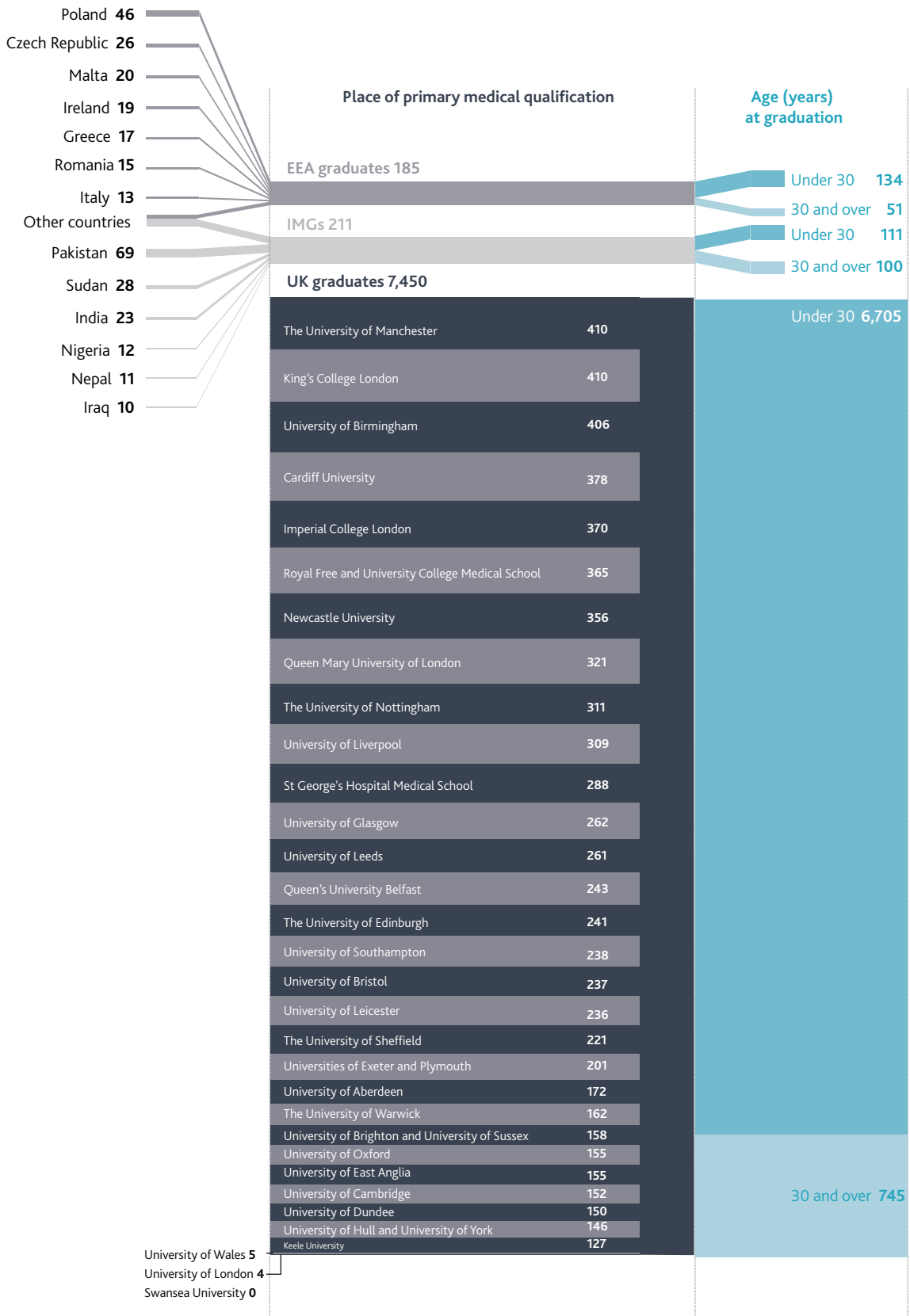
During 2012–14, the number of non-UK graduates in foundation training fell slightly and the number of UK graduates rose, but EEA graduates and IMGs account for only 4% of foundation doctors in 2014, so these differences over time are small.

Figure 10: Where F1 and F2 doctors were awarded their primary medical qualification in 2014 and their age at graduation

F1 DOCTORS



F2 DOCTORS



Who were the licensed doctors in 2014?

There are three main types of doctor – GPs, specialists, and doctors who are neither. Doctors who are neither may have roles that do not need these qualifications, or they may need further training to qualify for entry to the GP or Specialist Register.

The number of licensed specialists grew by 13% during 2010–14, compared with 4% for licensed GPs (figure 11).

The number of doctors not on the GP or Specialist Register or in training has decreased by 4% since revalidation was introduced in 2012 (from 47,501 that year to 45,572 in 2014).

Younger doctors of all types are increasingly likely to be female* and, for the first time, the total number of female GPs was higher than that of male GPs in 2014. 69% of doctors training to become GPs are female, so this trend is certain to increase.

Apart from general practice, medicine and psychiatry are the specialty groups in which female doctors are almost achieving equality in numbers.

In 2014, about five in ten psychiatrists, five in ten obstetricians and six in ten paediatricians were female. The majority of doctors training in each of these specialties are female, and these majorities have increased each year during 2012–14.

Figure 11: Gender and age (years) of licensed doctors in 2014 and change since 2010*

Type of doctor	Gender and age (years)			Change during 2010–14	
	Under 40	40–49	50 over	Overall number	50 years and over
GPs	18,437	17,819	24,023	4% ▲	2% ▲
% female	63%	56%	37%		
Specialists	13,727	29,838	29,817	13% ▲	13% ▲
% female	42%	37%	25%		
Other doctors†	24,293	11,046	10,233	-4% ▼	-17% ▼
% female	50%	38%	32%		

* For full number set, please go to www.gmc-uk.org/somep2015.

† Doctors on neither the GP nor the Specialist Register and not in training.

* See Section 1 of *The state of medical education and practice in the UK report 2014* for more on the increase in the number of female doctors.⁵⁷

Figure 12: Gender and age (years) of licensed doctors in the ten largest specialty groups in 2014 and change since 2010*

FOUR LARGEST SPECIALTY GROUPS				Change during 2010-14	
Specialty groups	Gender and age (years)			Overall number	50 years and over
	Under 40	40-49	50 and over		
Medicine % female	3,787 48%	7,653 37%	6,879 22%	20% ▲	16% ▲
Surgery % female	2,026 19%	5,533 13%	5,697 6%	15% ▲	18% ▲
Anaesthetics and intensive care medicine % female	1,990 38%	4,222 36%	3,595 26%	10% ▲	18% ▲
Psychiatry % female	1,592 44%	3,082 45%	3,510 37%	6% ▲	5% ▲

NEXT SIX LARGEST SPECIALTY GROUPS				Change during 2010-14	
Specialty groups	Gender and age (years)			Overall number	50 years and over
	Under 40	40-49	50 and over		
Radiology % female	1,232 41%	2,221 40%	1,996 29%	10% ▲	7% ▲
Paediatrics % female	938 60%	2,274 55%	2,064 42%	18% ▲	19% ▲
Obstetrics and gynaecology % female	469 61%	1,602 60%	1,792 35%	15% ▲	21% ▲
Pathology % female	491 56%	1,012 53%	1,542 34%	<-1% ▼	3% ▲
Ophthalmology % female	425 34%	877 32%	896 19%	18% ▲	17% ▲
Emergency medicine % female	619 39%	806 34%	530 19%	35% ▲	29% ▲

* We have split the data for the ten largest specialty groups to make the data for the six smaller specialty groups easier to read. For full number set, please see the GMC reference data, available at www.gmc-uk.org/somep2015.

The proportion of GPs and specialists who are BME UK graduates is increasing

The proportion of UK graduate GPs who are black and minority ethnic (BME) increased to 17% in 2014. Overall the number of BME GPs increased by 22% during 2010–14.

Among specialists, 15% of UK graduates and 85% of IMGs are BME, so both are lower proportions than for GPs.

However, there has been a 29% increase in the number of BME specialists – during 2010–14.

A large proportion of BME IMGs (38%) are not on the GP or Specialist Register or in training.

IMGs with Asian or British Asian ethnicity have been providing increasing proportions of the workforces in obstetrics and gynaecology, paediatrics and psychiatry during 2010–14, but this trend now appears to be slowing. Between 2012 and 2014, the number of Asian IMG doctors in training for each of these specialties dropped by almost half. However, our data cannot account for Asian IMGs who may train in their countries of origin before coming to practise in the UK.

Figure 13: Ethnicity and place of primary medical qualification of licensed doctors in 2014 and change since 2010*

Type of doctor	Place of primary medical qualification and ethnicity			Change during 2010–14		
	UK graduates	EEA graduates	IMGs	Overall number	Non-UK graduates	BME
GPs	46,740	3,531	10,008	4% ▲	4% ▲	22% ▲
% BME	17%	13%	90%			
Specialists	44,368	11,321	17,693	13% ▲	21% ▲	29% ▲
% BME	15%	7%	85%			
Other doctors†	15,417	7,226	22,929	Change during 2012–14		
% BME	28%	14%	87%	Overall number	Non-UK graduates	BME
				-4% ▼	-7% ▼	3% ▲

* For full number set, please go to www.gmc-uk.org/somep2015.

† Doctors on neither the GP nor the Specialist Register and not in training.

Figure 14: Ethnicity and place of primary medical qualification of licensed doctors in the ten largest specialty groups in 2014 and change since 2010*†

FOUR LARGEST SPECIALTY GROUPS

Specialty groups	Place of primary medical qualification and ethnicity			Change during 2010-14		
	UK graduates	EEA graduates	IMGs	Overall number	Non-UK graduates	BME
Medicine	12,045	2,523	3,751	20% ▲	33% ▲	37% ▲
% BME	18%	7%	86%			
Surgery	7,657	2,906	2,693	15% ▲	20% ▲	29% ▲
% BME	17%	7%	84%			
Anaesthetics and intensive care medicine	6,166	1,414	2,227	10% ▲	8% ▲	23% ▲
% BME	11%	4%	82%			
Psychiatry	4,546	1,032	2,606	6% ▲	15% ▲	27% ▲
% BME	13%	7%	85%			

NEXT SIX LARGEST SPECIALTY GROUPS

Specialty groups	Place of primary medical qualification and ethnicity			Change during 2010-14		
	UK graduates	EEA graduates	IMGs	Overall number	Non-UK graduates	BME
Radiology	3,608	736	1,105	10% ▲	13% ▲	24% ▲
% BME	20%	8%	85%			
Paediatrics	2,812	751	1,713	18% ▲	29% ▲	35% ▲
% BME	15%	7%	87%			
Obstetrics and gynaecology	1,690	597	1,576	15% ▲	29% ▲	34% ▲
% BME	15%	9%	90%			
Pathology	1,732	441	872	<-1% ▼	6% ▲	7% ▲
% BME	11%	6%	79%			
Ophthalmology	1,111	554	533	18% ▲	30% ▲	30% ▲
% BME	25%	5%	83%			
Emergency medicine	1,444	157	354	35% ▲	46% ▲	49% ▲
% BME	12%	6%	88%			

* We have split the data for the ten largest specialty groups to make the data for the six smaller specialty groups easier to read.

† For full number set, please go to www.gmc-uk.org/somep2015.

The flow of licensed doctors onto and off the register

Looking at the flow of doctors allows us to see where doctors joining the GP and Specialist Registers are from, and why those who give up their licence to work as a doctor in the UK choose to do so.

Doctors' reasons for leaving the workforce change with age. The majority of doctors under 50 years old who are giving up a licence to practise are leaving to go overseas. This is true for both UK and non-UK graduates. For those over 50 the majority leave the register to retire, except in the case of non-UK graduates who are on neither register; 56% of those are going overseas.

In these figures the number of doctors in training covers all those in any year of training. Only those in their final year will join the GP or Specialist Register for that year. The reasons for leaving were gathered from exit questionnaires sent to doctors giving up their licence to practise. See the box, right, for a full explanation of how we defined gaining or giving up a licence to practise in the UK.

How we defined gaining and giving up a licence to practise in the UK

Gaining a licence to practise in the UK

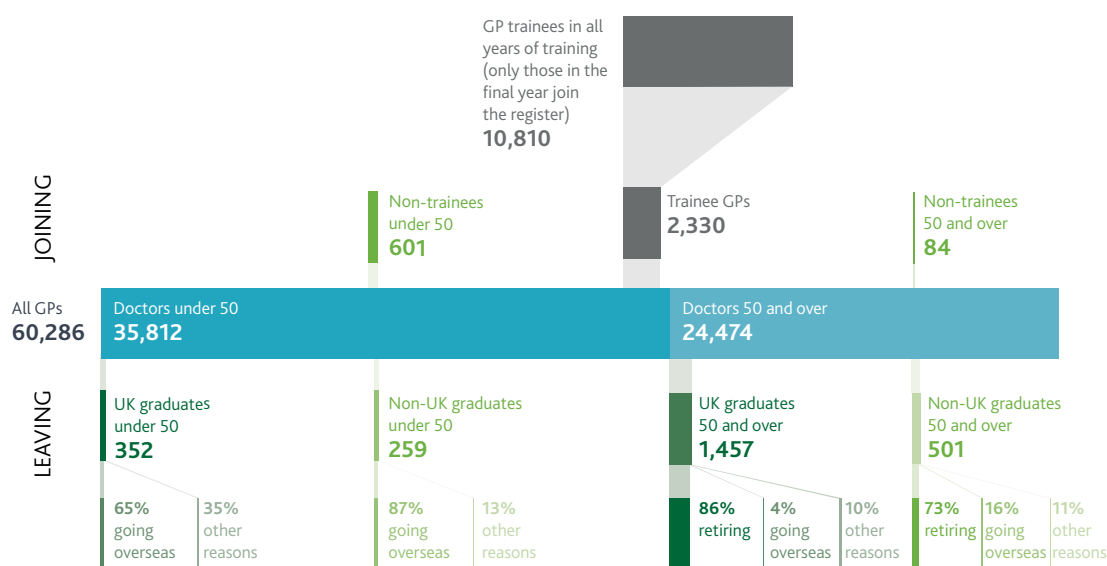
All doctors who were not on the register on 31 December 2012, but were on the register and licensed to practise on 31 December 2013.

Giving up a licence to practise in the UK

A doctor was defined as giving up their licence to practise in the UK when the following criteria were met: the doctor did not hold a licence to practise in the reported year, but had held a licence to practise in the year before, and additionally did not hold a licence to practise in the following year.

For the purposes of these figures this means the doctors who left the register in 2013 were those who held a licence to practise in 2012, but did not hold a licence to practise in 2013 or 2014.

Figure 15: Doctors joining and leaving the GP Register in 2013*



* Doctors joining who were trainees are shown in Figures 15 to 18 as being under 50 years old, though there may be a very small number aged 50 years old and over.

Figure 16: Doctors joining and leaving the Specialist Register in 2013

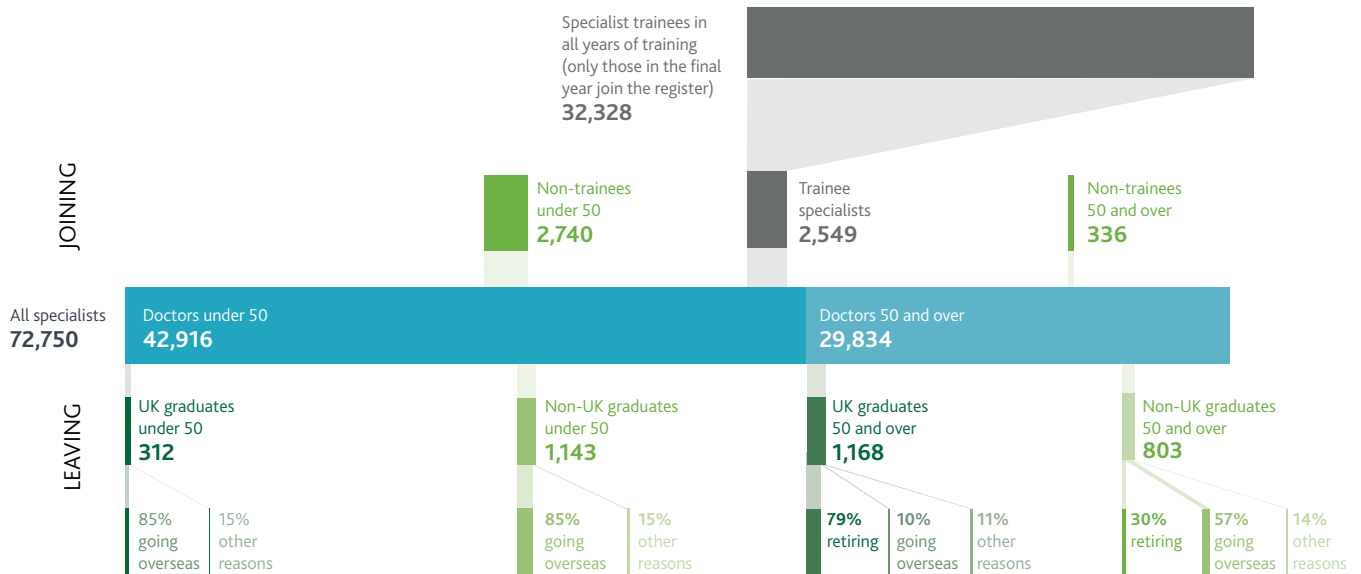
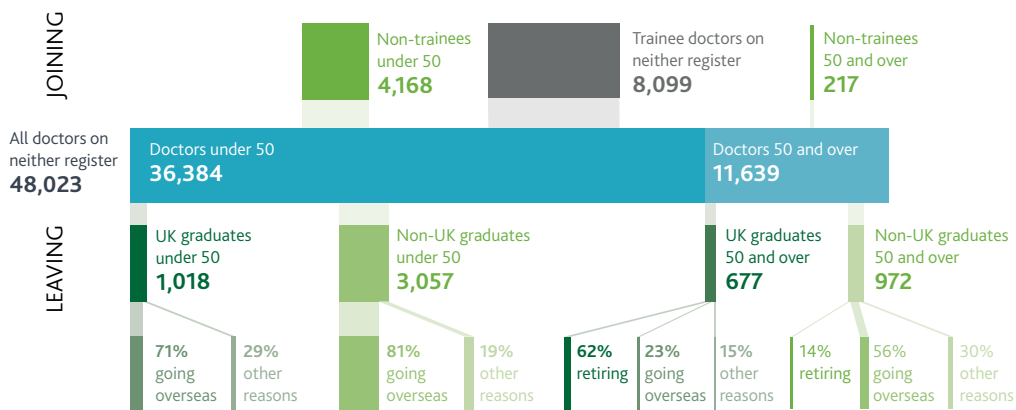
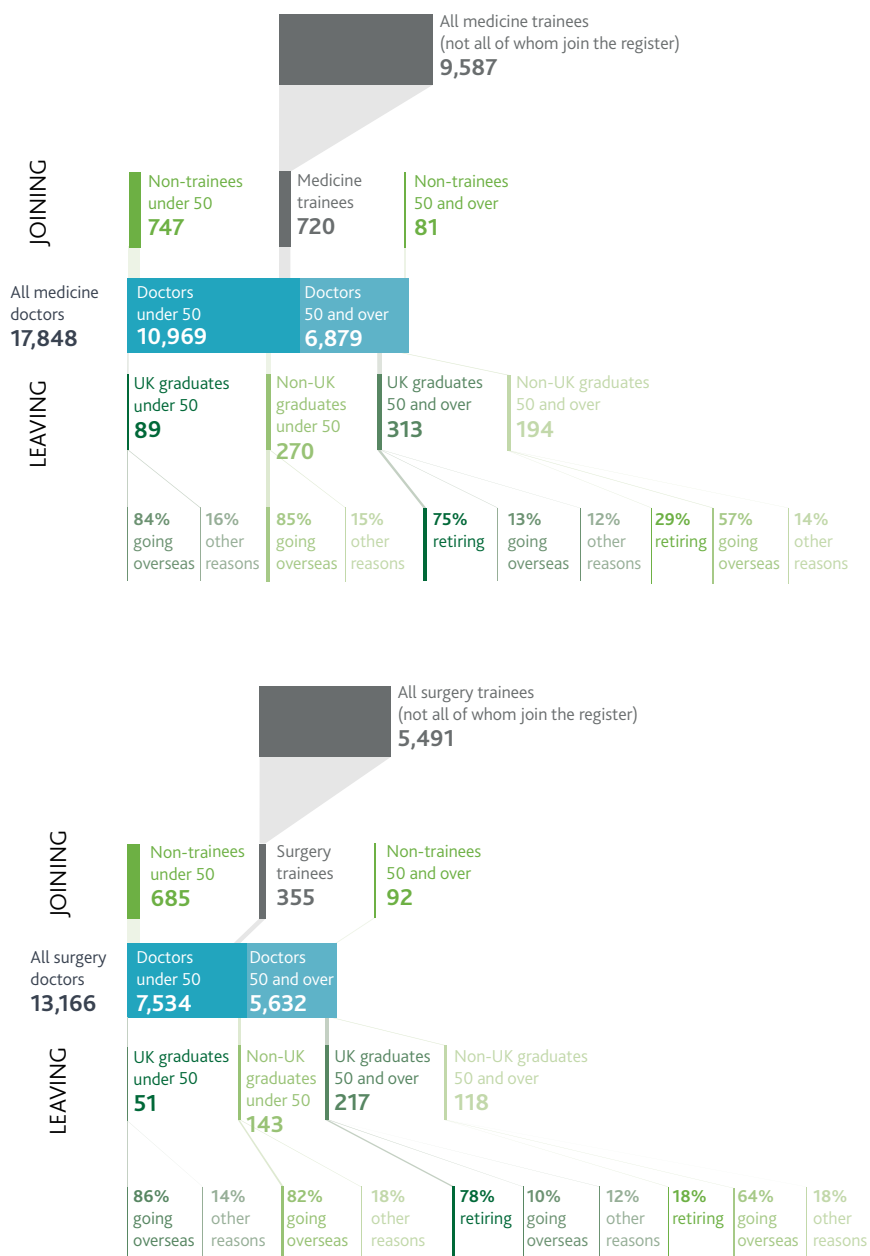


Figure 17: Doctors joining and leaving who are on neither register in 2013*



* In addition to those giving up a license to practise (as defined on page 44), many doctors moved from being on neither register to continue their training (4,515), to join the GP register (439), or to join the specialist register (1,675).

Figure 18: Doctors joining and leaving by specialty in 2013



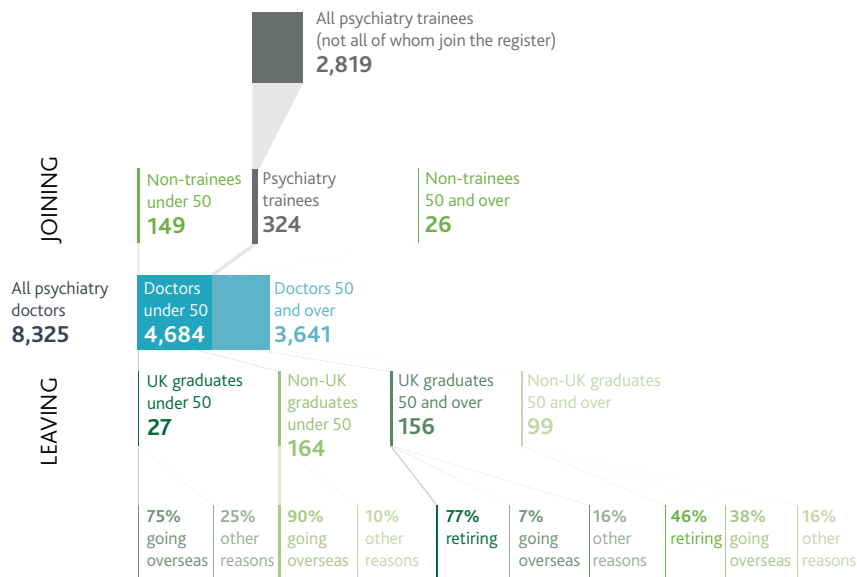
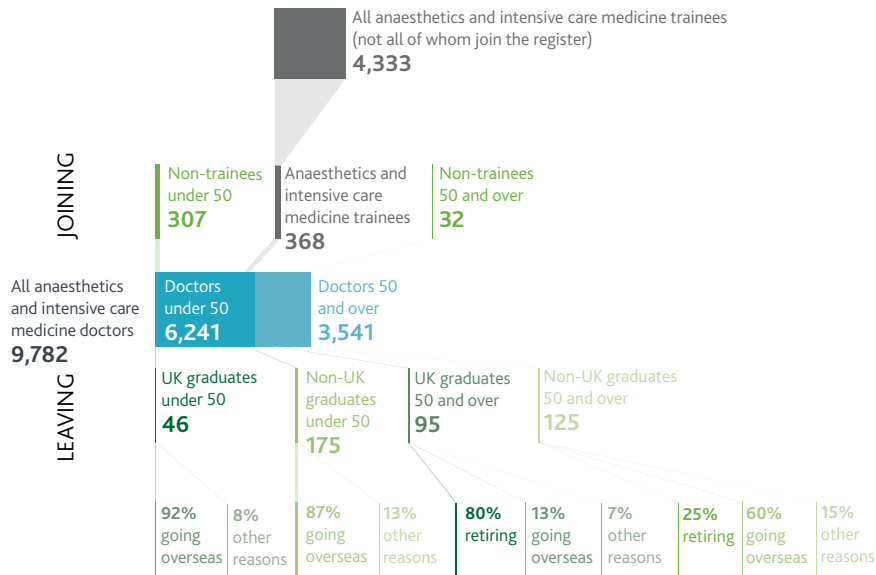
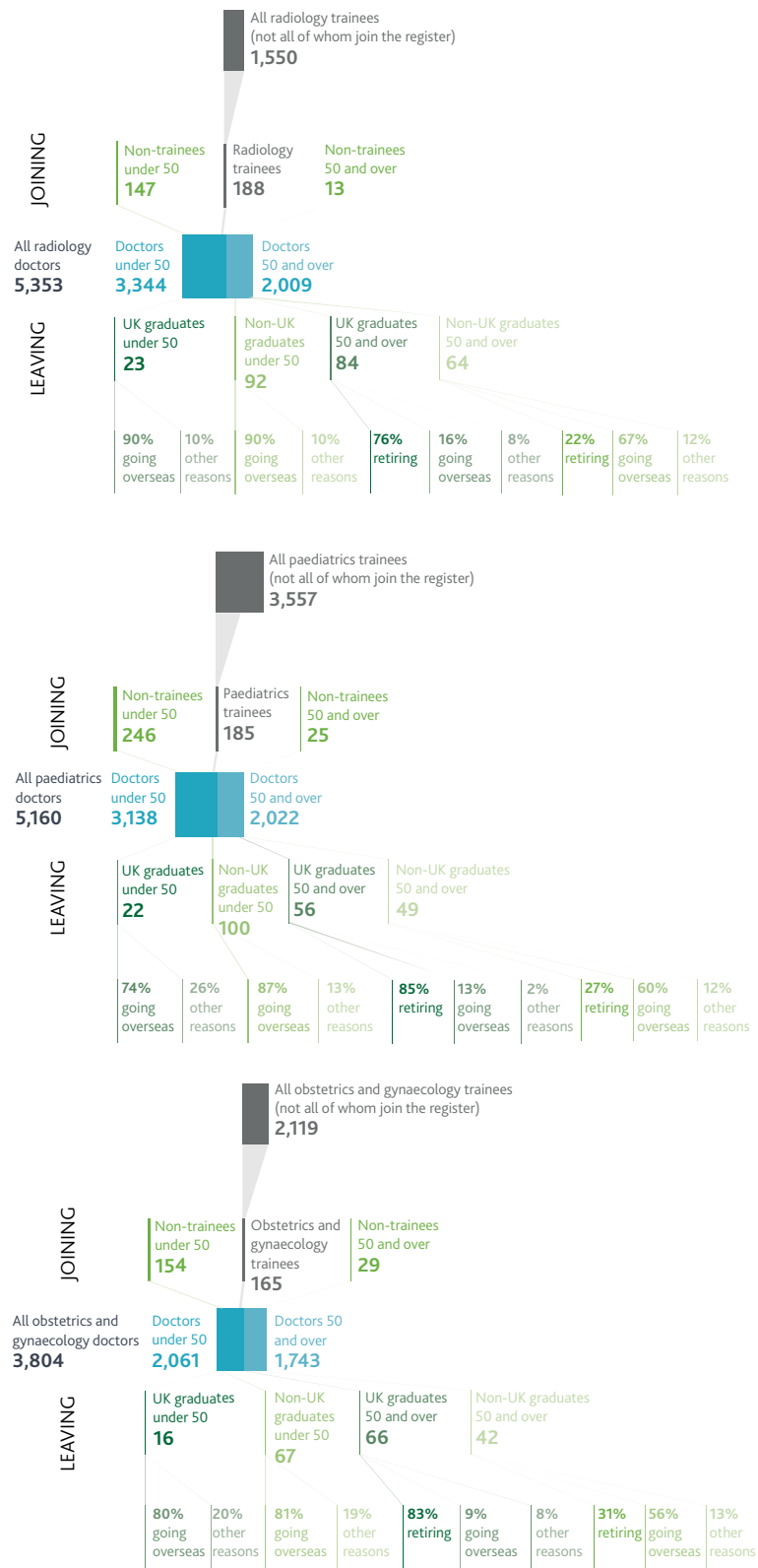
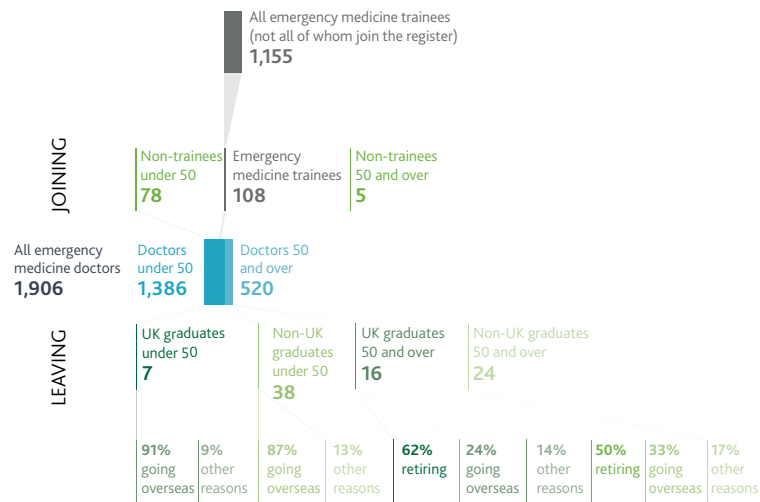
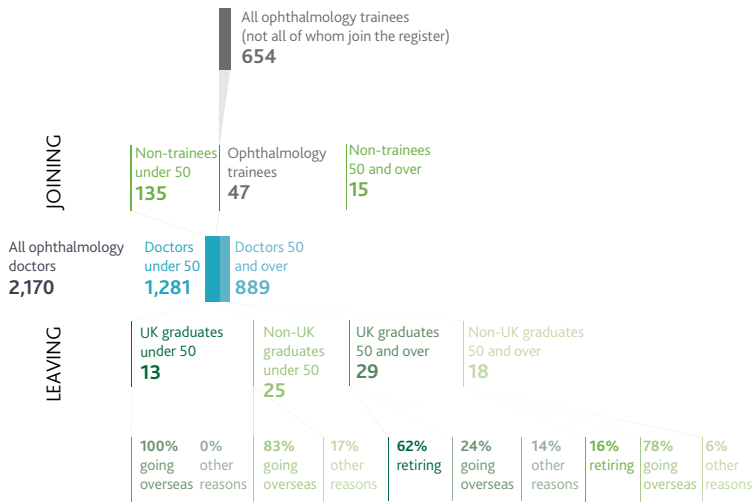
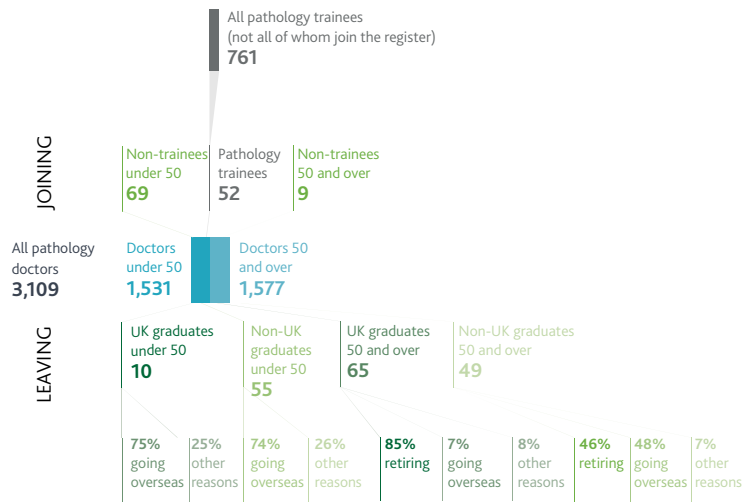


Figure 18: Doctors joining and leaving by specialty in 2013 (continued)





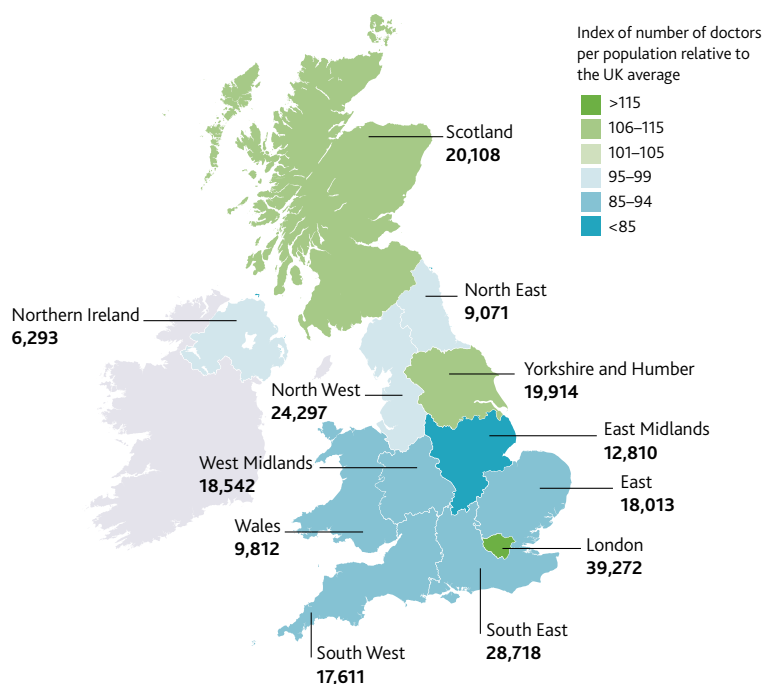
Regional differences in the types of doctor

In this section, we look at how the workforce of GPs, specialists and doctors who are neither on the GP nor the Specialist Register varies between different parts of the UK and regions in England. The maps are shaded so that darker areas indicate the greatest variation. Detailed data for each country and region in England are in the reference tables.*

Data across different parts of the UK

We have been able to allocate 89% of doctors on the medical register to one of the four parts of the UK or to a region in England (figure 19). This is based on the address of their workplace. Where that address cannot be linked to a part of the UK or a region of England – for example, because it is the address of a head office – we used the address at which doctors are attached for revalidation or the correspondence address held for that doctor.

Figure 19: Number of licensed doctors relative to the population for 2014



* Reference tables can be found at www.gmc-uk.org/somep2015.

The West Midlands has a slightly lower proportion of female doctors

Scotland, London and Northern Ireland have higher than average proportions of female doctors (figure 20). The area with the lowest proportion is the West Midlands, where 41% of licensed doctors are female.

Index of the proportion of female doctors relative to the UK average

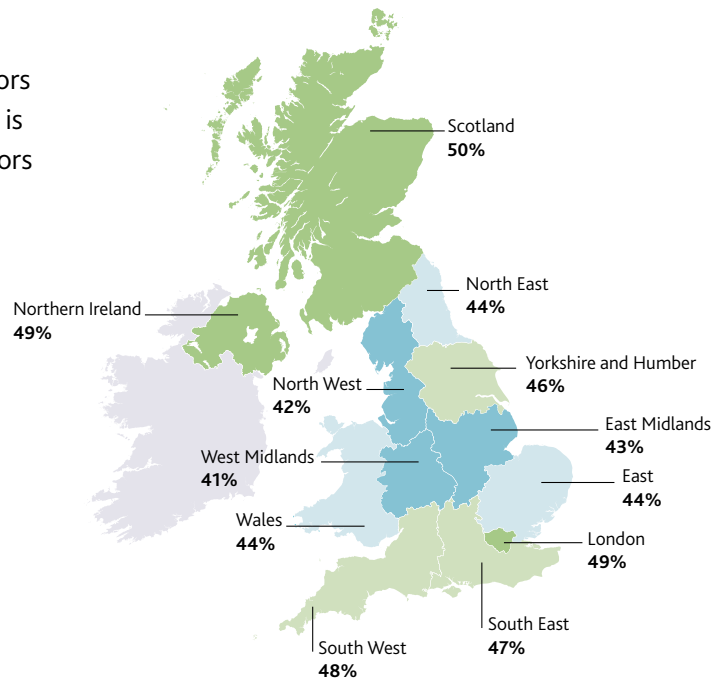
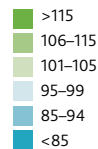
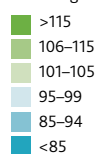


Figure 20: Proportion of licensed female doctors across the UK in 2014

There is little difference in the proportion of older doctors in certain areas

The two areas with the highest proportion of doctors aged 50 and over are Wales and East of England with 29%, which is slightly higher than the average of 27% (figure 21). London and Northern Ireland are the lowest at 25%.

Index of the proportion of doctors aged 50 years and over relative to the UK average



There is little difference in the age profile of doctors between regions, ranging from 25% aged 50 years and over in Northern Ireland and London to 29% in Wales and the East of England.

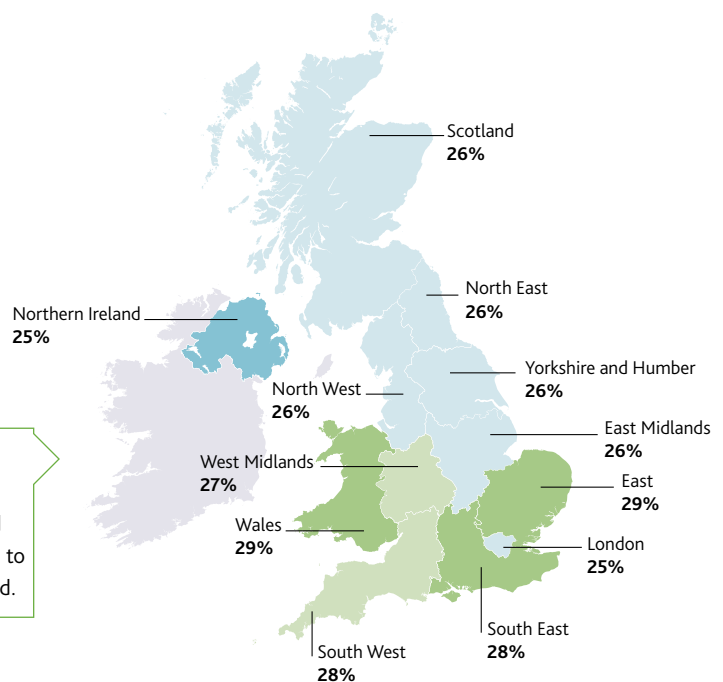
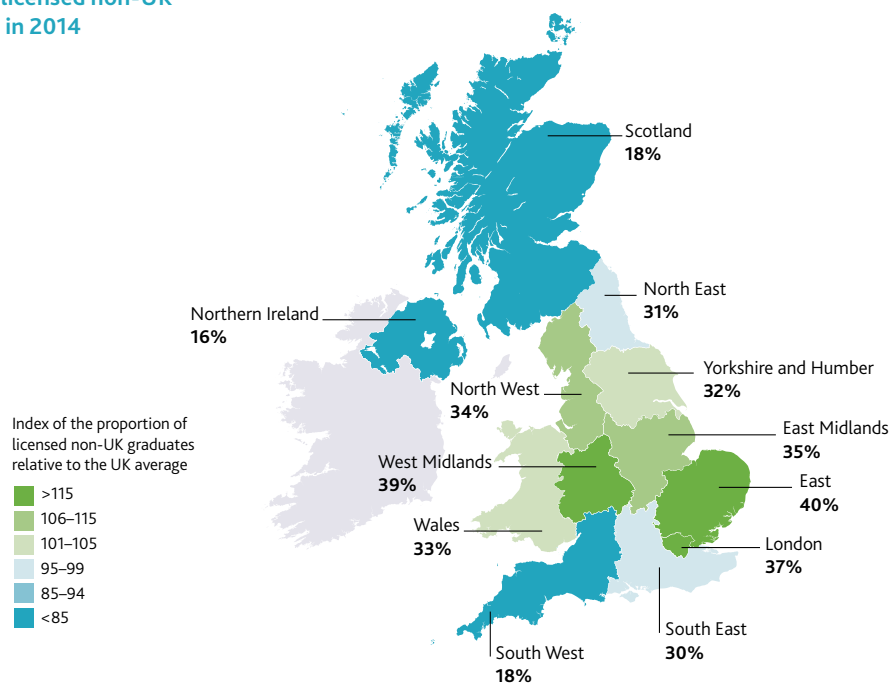


Figure 21: Proportion of licensed doctors aged 50 years and over across the UK in 2014

Figure 22: Proportion of licensed non-UK graduates across the UK in 2014



Northern Ireland, the South West of England and Scotland have the lowest proportion of non-UK graduates

Certain areas have lower proportions of doctors who are non-UK graduates, including Northern Ireland, Scotland the South West of England (figure 22). The East of England and the West Midlands have the highest proportions.

Between every country and region, the differences in the proportion of BME doctors follow the same pattern as that of non-UK graduates, with Northern Ireland having the lowest proportion of BME doctors.

World migration of doctors

Figure 23 (page 54–55) shows the countries where doctors with a licence to practise in the UK gained their primary medical qualification. The regions in which more doctors graduated are darker, such as south Asia.

The blue bar shows the number of doctors who gained a licence to practise in 2013, and the green bar shows the number who gave up their licence to practise in 2013. The arrows and percentages show the increase or decrease since the start of 2011, indicating which regions are providing fewer doctors who can practise in the UK.

Increase in doctors from countries with economic recession

There has been an increase in the number of graduates from Greece, Italy, Portugal and Spain with a UK licence – 2,107 during 2011–13. These countries each had high unemployment rates of 12.7–26.5% in 2014, compared with 6.1% in the UK.⁵⁸

Bulgaria and Romania were granted free movement across Europe in 2007 which increased the number of graduates joining the register and gaining a UK licence by 369 and 1,030 respectively during 2011–13.

The rate at which new doctors from both Bulgaria and Romania are joining the register and gaining a UK licence has slowed since 2010. It is possible that more graduates from Croatia will gain a UK licence once free movement is allowed following that country's admission to full EEA membership in 2014.

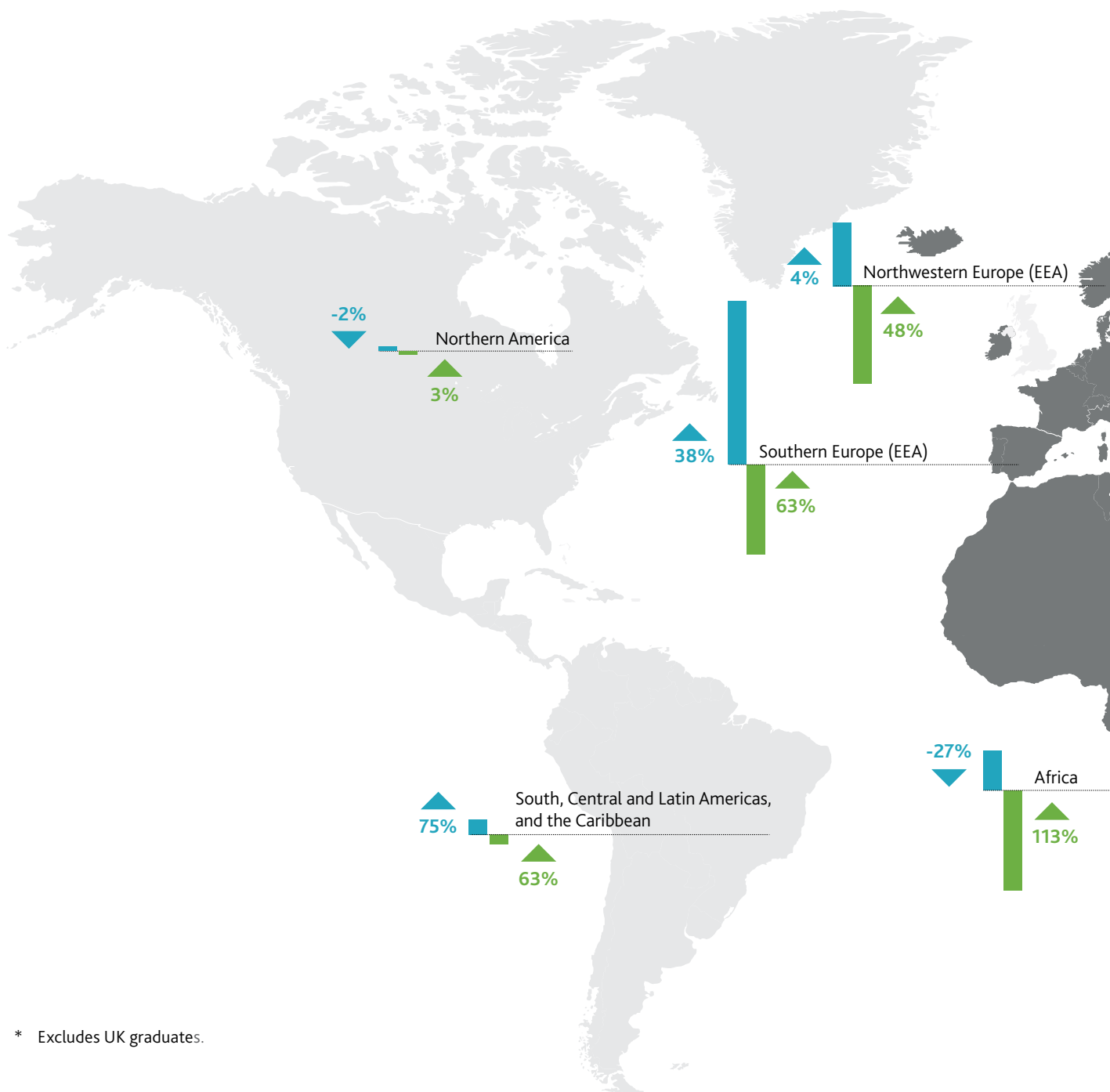
An increasing number of graduates from most European countries, including Greece, Italy, Portugal and Spain, gave up their UK licence during 2010–13.

Fewer graduates from Africa, particularly South Africa, Nigeria and Sudan, are gaining a UK licence

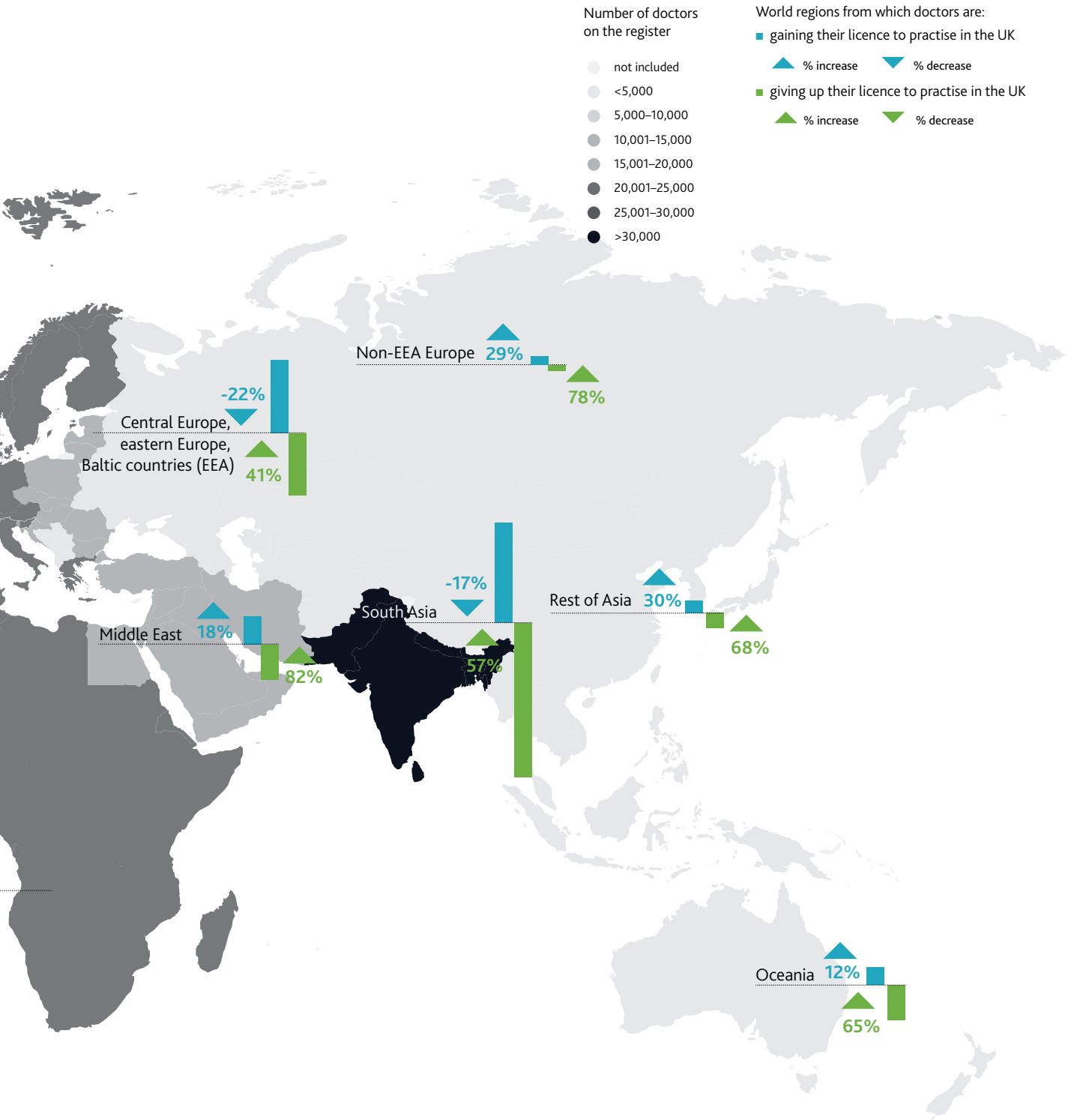
In 2013, fewer graduates from Africa gained a UK licence than in 2011, particularly those from Nigeria and Sudan. Additionally a higher number of graduates from Nigeria and Sudan gave up their UK licence over the same period. Despite this, 649 Nigerian graduates gained a UK licence during 2011–13.

The largest decrease in the number of licensed doctors during 2011–13 is among those who graduated in South Africa (–478) and in India (–469), with an increasing number of doctors giving up, and fewer gaining, a UK licence. During 2011–13, 1,616 graduates from Pakistan gained a UK licence, 79% of whom were under 40 years old.

Figure 23: Doctors gaining and giving up their licence to practise in the UK during 2010–13, by the world region* where they gained their primary medical qualification



* Excludes UK graduates.



Conclusions

The data do not support the claims of an ageing GP workforce⁵⁹ (figure 11, page 40). There are significant staffing challenges for GP surgeries, with the need for around a fifth more GPs to meet patient demand.⁶⁰ However, there is still a flow of young doctors into general practice. There is also no evidence that GPs are leaving the profession at a faster rate than other doctors.

From the most recent data, it is clear that the proportion of specialists leaving the medical register was around the same (4.8%) as that of GPs (4.4%).

Nevertheless, it is evident that there are areas of concern in the current make-up of the profession, and there are other areas that could become a concern in future. In particular, the data suggest there are risks around an increasing and high reliance on older doctors, and an increasing and high reliance on non-UK graduates.

A high reliance on older doctors

For obvious reasons, older doctors are more likely to leave the medical profession than those under 50 years old.

There are a range of age profiles across the ten largest specialty groups. The oldest age profile is in pathology with 51% over 50 years old. The overall number of pathologists fell by 0.5% between 2010 and 2014, while the number of pathologists over 50 years old rose by 3%.

An increasing reliance on older doctors

Pathology is the only specialty that has more doctors aged 50 years old and over than under 50 years old, but other specialty groups are also seeing an increasing proportion of older doctors.

During 2010–14, half of the specialty groups studied for this report saw the number of doctors aged 50 years old and over grow at a faster rate than the specialty group itself. This applied to surgery, anaesthetics and intensive care medicine, paediatrics, obstetrics and gynaecology, and pathology.

It is not clear whether this changing age profile of specialty groups indicates a risk. These data should be taken in the context of a population that is living healthier lives for longer, and therefore working longer.

At current rates of increase, it is unlikely that any of these specialties (other than Pathology) will see a majority of doctors aged 50 years old and over within the next 20 years, but an increasingly older specialty might be at more risk of losing numbers through retirement within that timescale.

A high reliance on non-UK graduates

Non-UK graduates from some world regions are increasingly giving up their UK licence to practise, either to retire or to work abroad. Doctors who graduated in countries that still have high unemployment rates are a notable exception to this.

As seen in figure 14 (page 43), in 2014, obstetrics and gynaecology was the only specialty in which the majority of doctors were non-UK graduates (56%). But almost half of ophthalmology doctors (49%) are non-UK graduates, and the number of non-UK graduates is growing faster than the number of UK graduates.

An increasing reliance on non-UK graduates

Overall the number of UK graduates gaining a UK licence to practise is increasing, but some specialties have an increasing proportion of non-UK graduates.

Among specialists, the number of non-UK graduates grew much faster than that of UK graduates during 2010–14 (see figure 13, page 42). As seen in figure 14, several specialty groups saw substantially greater increases in the number of non-UK graduates:

- medicine (33% non-UK graduates vs 20% overall)
- psychiatry (15% vs 6%)
- paediatrics (29% vs 18%)
- pathology (6% vs <-1%)
- ophthalmology (30% vs 18%)
- obstetrics and gynaecology (29% vs 15%)
- emergency medicine (46% vs 35%).

Chapter two: Complaints about doctors

This chapter sets out the types of complaint received by the GMC and how these complaints are resolved.

Over the five years from 2010–14, complaints about doctors to the GMC increased by 54%.

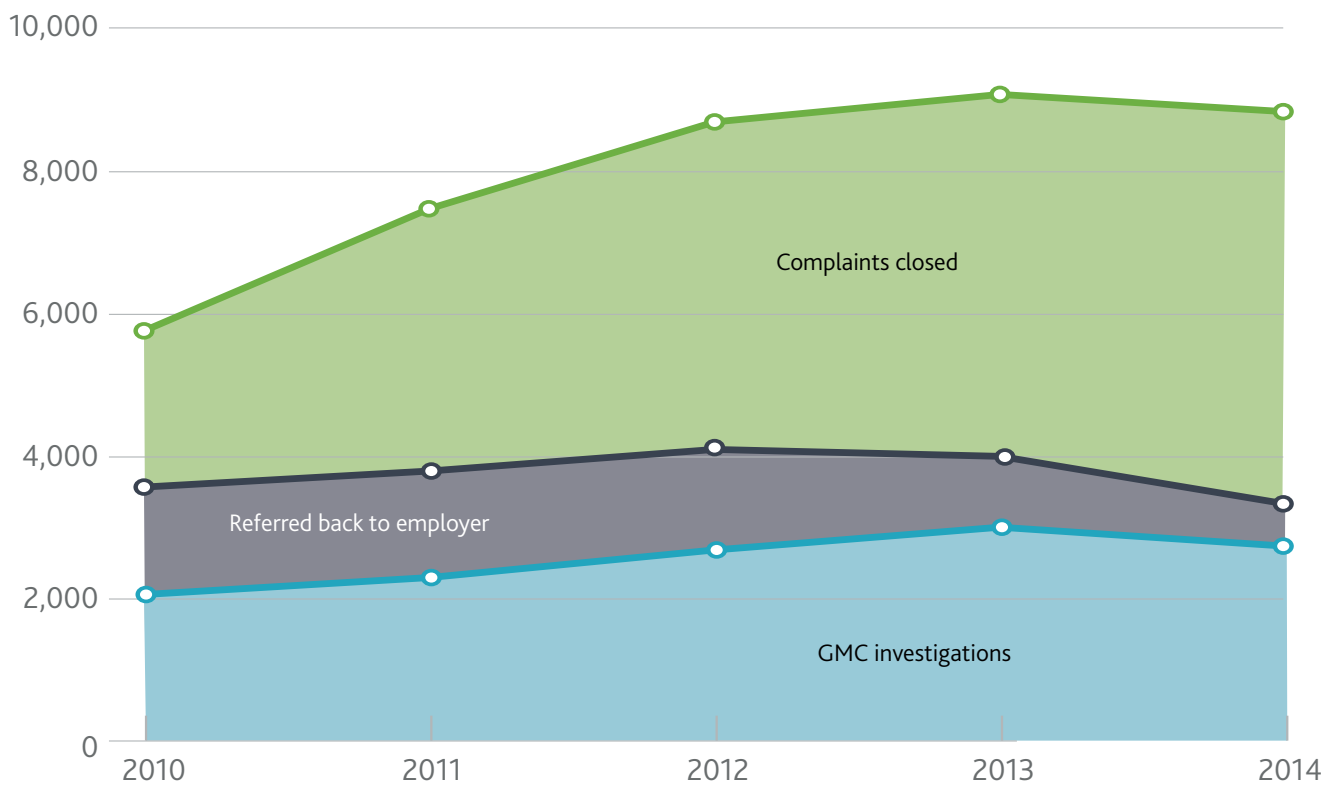
However, there has been a slowdown from 2012–13, which continued in 2014. It is not possible to tell whether this is the end of a rapid increase in complaints or if the five-year trend of increasing complaints will continue in the long term. The fitness to practise processes that can occur after a complaint is made are shown in figure 25, page 60–61.

The number of complaints received decreased in 2014

2014 saw a small drop of 2.3% in the number of complaints the GMC received compared with 2013 (figure 24). There were also fewer complaints that the GMC investigated (8.8% fewer) or referred back to the doctor's employer to deal with (down 40%). The number of complaints the GMC closed immediately following receipt increased by 8.4%.

The data in this chapter refer to complaints made and investigations opened, along with the outcomes of these cases, based on the year the enquiry is received by the GMC, rather than the year in which the complaint or investigation is closed.*

Figure 24: The numbers of complaints and investigations received by the GMC during 2010–14



* The exception to this is figure 26 (page 63) which is based on activity occurring within the year.

Figure 25: How the GMC handled enquiries about doctors in 2014



Enquiries not about a doctor's fitness to practise **862**

There were over 800 enquiries recorded that were not about a doctor's fitness to practise. This is just over half the number of such enquiries received in 2012.

- * These are complaints about: a doctor's conduct and professional performance (eg serious or persistent clinical errors, failures to provide appropriate treatment or care, serious breaches of our guidance); serious impairment of a doctor's practice because of physical or mental ill health; a doctor receiving a conviction or caution inside or outside the UK; or a doctor being a risk to patients.
- † These include 75 resolved cases of voluntary erasure and one resolved case of administrative erasure, and 15 cases where the complaint has been withdrawn.
- ‡ These decisions will be taken by the MPTS fitness to practise panel. In some cases, case examiners are able to issue a warning or agree an undertaking with the doctor after the investigation.

Closed with advice **213**

These complaints were closed after an investigation, with advice given to a doctor about their conduct by a GMC case examiner.

Still being investigated **957**

These complaints were unresolved on 8 July 2015.

Sanction or warning given **152**

These complaints led to a sanction or a warning, which included agreeing or imposing restrictions on a doctor's practice, or suspending or erasing them from the register.‡

Warning given **79**

These complaints led to the doctor being given a warning about some aspect of their work, but they can continue working as a doctor in the UK without any restrictions.

Conditions or undertakings **51**

These complaints led to the doctor agreeing to restrictions, or having restrictions imposed, on their work – eg working only under medical supervision or committing to retraining.

Suspended or erased **22**

These complaints led to the doctor being suspended or erased permanently from the register, preventing them from working as a doctor in the UK.

What outcomes do cases result in?

Figure 25 on pages 60-61 shows the range of outcomes possible after a complaint is raised with the GMC. In the most serious cases it may be concluded that is not safe or appropriate for the doctor to continue practising and the doctor will be suspended or erased. If the doctor's practice is impaired, but it is safe for the doctor to continue practicing with appropriate support, supervision or re-training then conditions or undertakings will be applied to ensure this. If the doctor's practice is not impaired, but there is evidence of a smaller breach of standards then a warning will be issued. Other cases are closed without sanction or warning. Sometimes when they are closed some advice will also be provided where there has been a very low-level breach of standards that does not merit a warning. The fitness to practice processes that can occur after a complaint is made are shown in figure 25 on the previous page.

In this section the data refer to cases that were closed in the five-year period from 2010–14. Most of the variation in the number of cases simply reflects the variety of cases raised each year, but some is caused by changes in the GMC's processes.

Figure 26 (page 63) shows that the number of cases that were closed with no further action increased by 121% during 2010–14 and that the number of cases ending in conditions or undertakings increased by 23%. The increase in the number of cases closed with no further action is linked to the increase in the number of complaints overall.

Many of these additional cases appeared serious enough to warrant investigation, but subsequently turned out not to be serious, or were cases where the doctor had already remediated and was no longer judged to be at risk of repeating the incident.

In response to this trend, the GMC is reforming the initial triage process so it can more accurately judge which enquiries merit an investigation. The increase in the number of undertakings has arisen as a result of a public consultation in 2009, which resulted in an extended range of cases being made eligible for undertakings.⁶¹

Conversely, the number of cases closed with advice decreased by 42% between 2010 and 2014. This is due to a change in the GMC's process for issuing advice, which led to advice being issued only for low-level breaches of *Good medical practice* and where the facts are admitted or beyond doubt. This means that more cases are now closed with no further action.⁶² The number of warnings also decreased by 29%. This was not due to a change in policy and may reflect the normal variation in cases seen each year.

Figure 26: Outcomes of investigated cases closed each year

	2010	2011	2012	2013	2014
INVESTIGATIONS COMPLETED					
Investigated	1,856	2,263	2,348	2,596	2,696
CASES INVESTIGATED NOT RESULTING IN A SANCTION OR A WARNING					
No further action	884	983	1,062	1,900	1,952
Closed with advice	460	726	831	217	265
CASES INVESTIGATED RESULTING IN A SANCTION OR A WARNING					
Warning given	184	207	176	149	131
Conditions or undertakings	132	170	155	182	162
Suspension	99	111	63	77	101
Erasure	97	66	61	70	85

Where do complaints come from?

Who makes complaints about doctors?

The GMC receives complaints from a wide range of sources (figure 27, page 65). In 2014, the police referred 13% fewer complaints than they did in 2010, the only source to make fewer complaints in this period. The largest increase was in complaints from doctors,* which almost doubled (up 95%). There were also substantial increases from those acting in a public capacity† (72%), members of the public (51%), the GMC itself (45%) and employers (37%).

The public – which includes patients and patients' relatives – has made the greatest number of complaints every year since 2010. The proportion of complaints from the public remained similar between 2010 and 2014. The proportion of complaints from the police fell by 43% (from 2.9% in 2010 to 1.7% in 2014), and the proportion from doctors rose by 27% (from 11% in 2010 to 14% in 2014).

Cases opened by the GMC on its own initiative, for example as a result of media coverage, increased in 2010-12 but have fallen again more recently. This may be due to improved communication between the GMC and the Responsible Officers‡ in organisations, resulting in a better initial understanding of the issues before deciding whether there is a need to open a case.

As the number of complaints from the public rose sharply in 2011, the proportion that resulted in an investigation fell. Although the proportion rose again in 2013, it has still not reached 2010 levels.

Across this five-year period from 2010–14, the number of complaints from almost all sources has increased, but there has been a slight fall in most areas between 2013 and 2014.

* If a senior doctor (for example, the clinical director) or human resources manager or similar raises a concern on behalf of the organisation they work for, the GMC considers it to be raised by the employer. If a doctor at any level raises a concern that is not on behalf of the organisation – for example, a personal grievance – it is categorised as a concern raised by another doctor. A self-referral by a doctor will count as a complaint in this category as well.

† This includes people acting on behalf of other public organisations, such as the coroners office or other regulatory bodies.

‡ Responsible Officers are responsible for the revalidation of doctors, and making sure doctors with restrictions are safely and appropriately managed.

Figure 27: Number of complaints and investigations from each source in 2010–14

	2010	2011	2012	2013	2014
EMPLOYERS					
Complaints	431	493	610	596	589
% investigated	89%	86%	83%	93%	81%
Investigations	385	425	508	553	478
POLICE					
Complaints	170	176	165	161	148
% investigated	64%	67%	69%	63%	60%
Investigations	109	118	114	101	89
OTHERS ACTING IN A PUBLIC CAPACITY					
Complaints	410	495	565	721	705
% investigated	63%	65%	67%	64%	56%
Investigations	260	320	379	459	396
GMC					
Complaints	246	530	955	535	357
% investigated	66%	47%	31%	30%	36%
Investigations	162	249	295	162	128
DOCTORS					
Complaints	654	833	900	1,151	1,277
% investigated	55%	51%	45%	46%	38%
Investigations	362	427	404	526	489
PUBLIC					
Complaints	3,858	4,955	5,504	5,929	5,808
% investigated	21%	16%	18%	20%	20%
Investigations	793	770	996	1,214	1,170

BOX 1: The types of allegation assigned to complaints

When the GMC receives a complaint about a doctor, the allegations are assessed and assigned to different categories – such as criminality or failing to act honestly and fairly. One or more allegations can be assigned to help categorise the case. To analyse the complaints, we have grouped the most common and distinct types of allegation. These groups are used throughout this chapter. Each group is mutually exclusive – a case appears only once in any group.

- **All health allegations:** these cases are about the doctor's physical or mental health.
- **All criminality allegations except health:** these cases have arisen because of criminal behaviour by the doctor, that led to a conviction – this group includes cases with other allegations, but excludes those linked to allegations about the doctor's health.
- **Acting honestly and fairly allegations only:** these cases are about the doctor's failure to act honestly and fairly towards patients and others – this group excludes cases where there are also other types of allegation.
- **Acting honestly and fairly and other allegations:** these cases are about a doctor's failure to act honestly and fairly towards patients and others – this group includes cases which have other allegations, but excludes those with health, criminality and clinical competence allegations.
- **Acting honestly and fairly and clinical competence allegations only:** these cases are about a doctor's failure to act honestly and fairly towards patients and others, and to deliver good quality clinical care to patients – this group excludes cases which have other allegations.
- **Clinical competence allegations only:** these cases are about a doctor's failure to deliver good quality clinical care to patients – this group excludes cases which have other allegations.
- **Clinical competence and communication and respect for patients allegations only:** these cases are about a doctor's failure to deliver good quality clinical care to patients, and to communicate appropriately and respectfully with patients – this group excludes cases which have other allegations.
- **Communication and respect for patients allegations only:** these cases are about a doctor's failure to communicate appropriately and respectfully with patients – this group excludes cases which have other allegations.
- **Professional performance allegations:** these cases are about a doctor's poor performance in the non-clinical aspects of their role – for example, failing to work well with colleagues, failing to appropriately report on cases or share information, or bullying and undermining colleagues. This group includes other allegations but excludes cases which have health, acting honestly and fairly, and criminality allegations.
- **Cases with other allegations:** these cases are about any allegation or combination of allegations not included above.

The types of complaint raised by the public differ from concerns raised by other sources

Figure 28 shows that most cases following complaints raised by the public were about clinical competence (51%) with nearly half of these also involving concerns about communication and respect for patients.

A further 9% were only about communication and respect for patients only, and 17% were about professional performance. 14% of cases stemming from complaints made by the public did not involve one of these three types of allegation.

Figure 28: Types of allegation assigned to cases from the public that were received by the GMC 2010–14

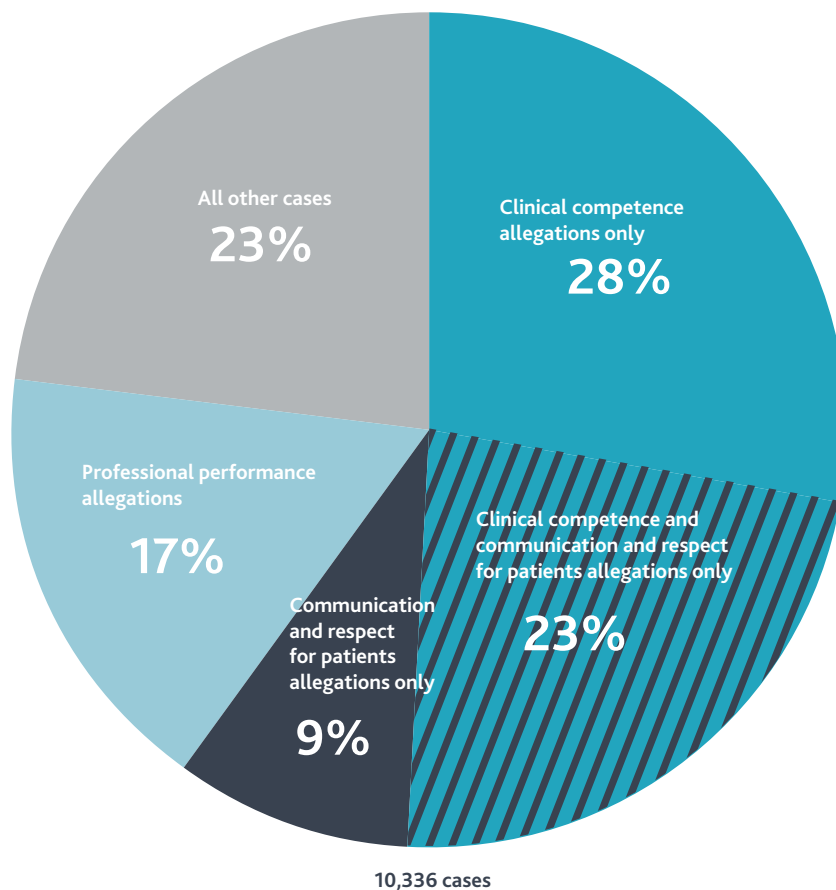


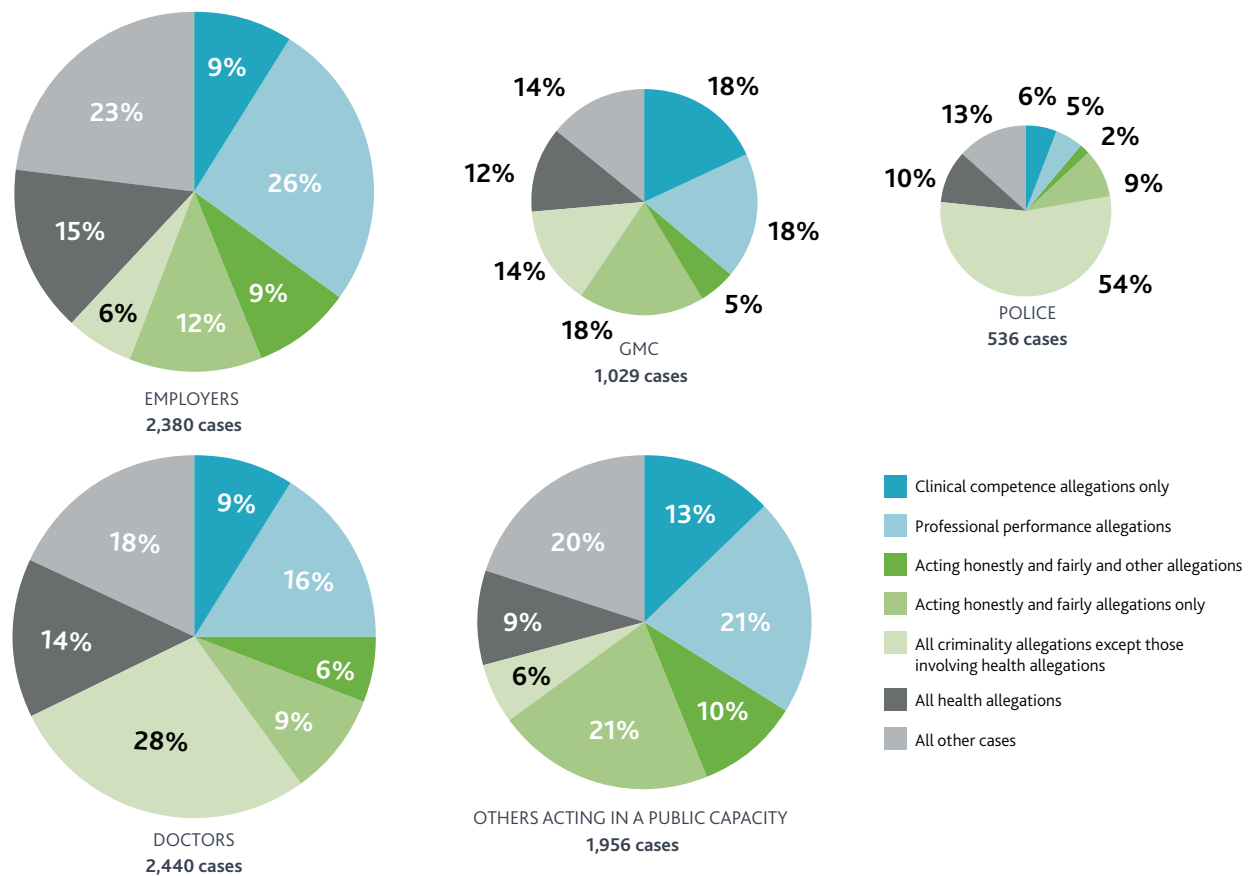
Figure 29 shows that cases involving only clinical competence were more likely to originate from the public (28%) or the GMC (18%). However, as we show later in figure 31, only a tiny proportion of cases involving clinical competence only from the public led to a sanction or a warning (3%) compared with 6% of those from concerns raised by all other sources.

Doctors are much more likely to raise matters relating to criminality than other sources apart from the police – 28% of concerns raised by doctors are about this. This is almost entirely due to self-reporting. Only a very small proportion of concerns raised by doctors in relation to other allegations are self-

reporting, with the vast majority being made about a doctor by another doctor. These cases had a relatively high likelihood of ending in a sanction or a warning: 36% and 12% respectively.

Health concerns accounted for about one in seven concerns raised by employers or doctors. For employers, concerns about professional performance were also important, accounting for one in four cases. Over 50% of cases from concerns raised by the police were unsurprisingly about criminality, with a further 12% involving allegations of doctors failing to act honestly and fairly.

Figure 29: Types of allegation assigned to cases from a range of sources that were received by the GMC during 2010–14*



* We have put all cases with a health allegation under the health category. This includes a small proportion of the cases that also had a criminality allegation (15%). In this figure, cases involving allegations of acting honestly and fairly and clinical competence only are counted in 'All other cases'.

Complaints about clinical competence and communication and respect for patients predominantly come from members of the public

As shown below in figure 30, different sources have different profiles of allegations in the cases which they refer to the GMC.

Over three-quarters of cases involving clinical competence and/or communication and respect for patients arose from complaints made by the public.

While 52% of cases about professional performance came from public complaints, a substantial proportion (30%) came from employers and other doctors.

By contrast, over half of health and criminality cases arose from concerns raised by employers or doctors, with a further 20% of criminality cases coming from the police. The majority of cases from doctors for criminality are self-referrals.

Cases involving honesty and fairness stemmed from a greater variety of sources, with about a third arising from the public, about a third from employers and other doctors, and about a third from other sources.

Figure 30: Types of allegation assigned to cases from different sources received in 2010–14

ALLEGATION TYPE	NUMBER OF CASES	% FROM EACH SOURCE			
		Employers	Doctors	Other*	Public
All health allegations	1,194	30%	30%	30%	11%
All criminality allegations except health	1,435	9%	47%	38%	6%
Acting honestly and fairly allegations only	1,638	18%	14%	39%	29%
Acting honestly and fairly and other allegations	1,119	20%	13%	24%	44%
Clinical competence and acting honestly and fairly allegations only	498	14%	10%	17%	60%
Clinical competence allegations only	3,798	6%	6%	12%	76%
Clinical competence and communication and respect for patients allegations only	2,604	2%	4%	4%	90%
Communication and respect for patient allegations only	1,154	7%	4%	6%	82%
Professional performance allegations	3,432	18%	12%	18%	52%

* This includes complaints raised the police, other organisations (including people acting in a public capacity) and the GMC.

The likelihood of allegations resulting in a sanction or a warning varies depending on the type of allegation

Figure 31 (page 71) shows that 92% of investigations involving clinical competence from members of the public resulted in no sanction or warning. Moreover, only a very small percentage of clinical competence investigations resulted in a sanction or a warning: 71% from other doctors and employers, and 76% from all others resulted in no sanction or warning. Similarly, a very small proportion of investigations about professional performance and about communication and respect for patients resulted in a sanction or a warning, especially those from the public: 85% and 93% respectively resulted in no sanction or warning.

Investigations involving health allegations made by employers or other doctors were the ones that were most likely to result in a sanction, with 49% and 52% respectively doing so.

Investigations involving criminality allegations from the police and employers were also among those more likely to result in a sanction. 35% of criminality cases from doctors resulted in a warning. This is partly due to self reporting of fairly minor offences, such as minor traffic offences.

Most investigations involving honesty and fairness allegations made by the public resulted in no sanction or warning (89%), but 20% from doctors and employers and 17% from others did result in a sanction or a warning.

Figure 31: Proportion of GMC investigations* of complaints received in 2010–14 from different sources and with different types of allegation and their outcome as at July 2015

ALLEGATION TYPE AND SOURCE	NUMBER OF INVESTIGATIONS	% WITH EACH OUTCOME			
		No sanction or warning	Warning	Sanction	No decision on sanction or warning made
ALL HEALTH ALLEGATIONS					
Doctors	347	25%	1%	52%	22%
Employers	356	27%	1%	49%	23%
All others	460	41%	2%	34%	23%
ALL CRIMINALITY ALLEGATIONS EXCEPT HEALTH					
Doctors	673	52%	35%	6%	7%
Employers	132	53%	10%	18%	19%
Police	288	46%	25%	19%	10%
ACTING HONESTLY AND FAIRLY ALLEGATIONS ONLY					
Doctors and employers	494	67%	11%	9%	13%
Public	348	89%	1%	2%	8%
All others	627	67%	7%	11%	16%
CLINICAL COMPETENCE ALLEGATIONS ONLY					
Doctors and employers	402	71%	2%	4%	22%
Public	1,511	92%	2%	1%	5%
All others	414	76%	4%	2%	18%
CLINICAL COMPETENCE AND COMMUNICATION AND RESPECT FOR PATIENTS ONLY					
Doctors and employers	125	82%	1%	3%	14%
Public	852	93%	1%	1%	5%
All others	94	81%	2%	3%	14%
PROFESSIONAL PERFORMANCE ALLEGATIONS					
Doctors and employers	929	61%	3%	13%	22%
Public	1,040	85%	5%	3%	8%
All others	580	70%	3%	7%	20%

* Figure 31 is based on investigations, not cases, and so excludes those cases where action is taken by a doctor's Responsible Officer or employer. The outcomes counted are final outcomes after all review stages. The majority of the investigations in the 'No decision on sanction or warning made' column are on-going, but some did not result in a decision for other reasons, for instance, the death of the doctor involved. Investigations following applications for doctors to be restored to the register after a sanction are also counted in this column.

Which doctors are most likely to be the subject of complaints raised by different sources?

Individual doctors are less likely than employers to raise concerns about older doctors

Nearly half (49%) of cases in 2010–14 were about doctors aged 50 years old or over, and only one in 23 were about those under 30 years old.

Doctors' complaints are less likely than those from employers to be about doctors 50 years old and older. 50% of concerns raised by employers were about doctors in this age group. In contrast, only 43% of complaints from doctors were about those aged 50 years or older.

Male doctors are significantly more likely to face allegations than female doctors; this is especially marked when it comes to cases involving criminality*

There is relatively little difference in the sources of complaints across different types of allegation with respect to gender. In most cases, male doctors accounted for 70–85% of cases. But some differences can be noted.

- Female doctors accounted for around a third of cases involving health that came from any source other than the police.
- Employers and the police were particularly likely to report concerns about male doctors that led to cases involving criminality: 88% of these investigations from employers and 87% from the police were about male doctors.
- 77% of cases with allegations assigned that only involve communication and respect for patients were about male doctors, and this is particularly true of concerns raised by employers (90%) and others acting in a public capacity (85%).

* According to the Ministry of Justice, the most recent available data for England and Wales show that in 2012–13 85% of those arrested were male, and only 15% female. For convictions in 2013 the data were 75% male and 25% female.⁶³ Older research indicates a similar situation in Scotland.⁶⁴

BME and non-UK graduates are overrepresented in all allegation groups

44% of all cases were about non-UK graduates and 56% were about UK graduates. A little under a quarter (22%) of the non-UK graduates investigated were European Economic Area (EEA) graduates and predominantly identified as white.

There were variations in the proportion of cases coming from different sources that were about BME doctors or about non-UK graduates.* Concerns raised by institutions – employers, the police and those people acting in a public capacity – were more likely to be about BME doctors and about non-UK graduates than concerns raised by individual doctors, the public or the GMC (figure 32, page 74).

A greater proportion of non-UK graduates are BME than UK graduates. It is possible that some of the higher incidence of BME doctors being referred by employers, the police or those acting in a public capacity may be a reflection of the higher referral rates for non-UK doctors rather than an issue for BME doctors specifically.

As figure 33 (page 74) shows, the difference between sources in the proportion of cases referred involving UK graduate BME doctors is smaller.

* Just over a fifth of cases in 2010–14 were about doctors whose ethnicity is unknown – this does not vary greatly between different sources. 44% of the remaining cases were about BME doctors and 56% were about white doctors.

Figure 32: Proportion of cases that are about BME doctors and about non-UK graduates, by the source of the complaint, in 2010–14

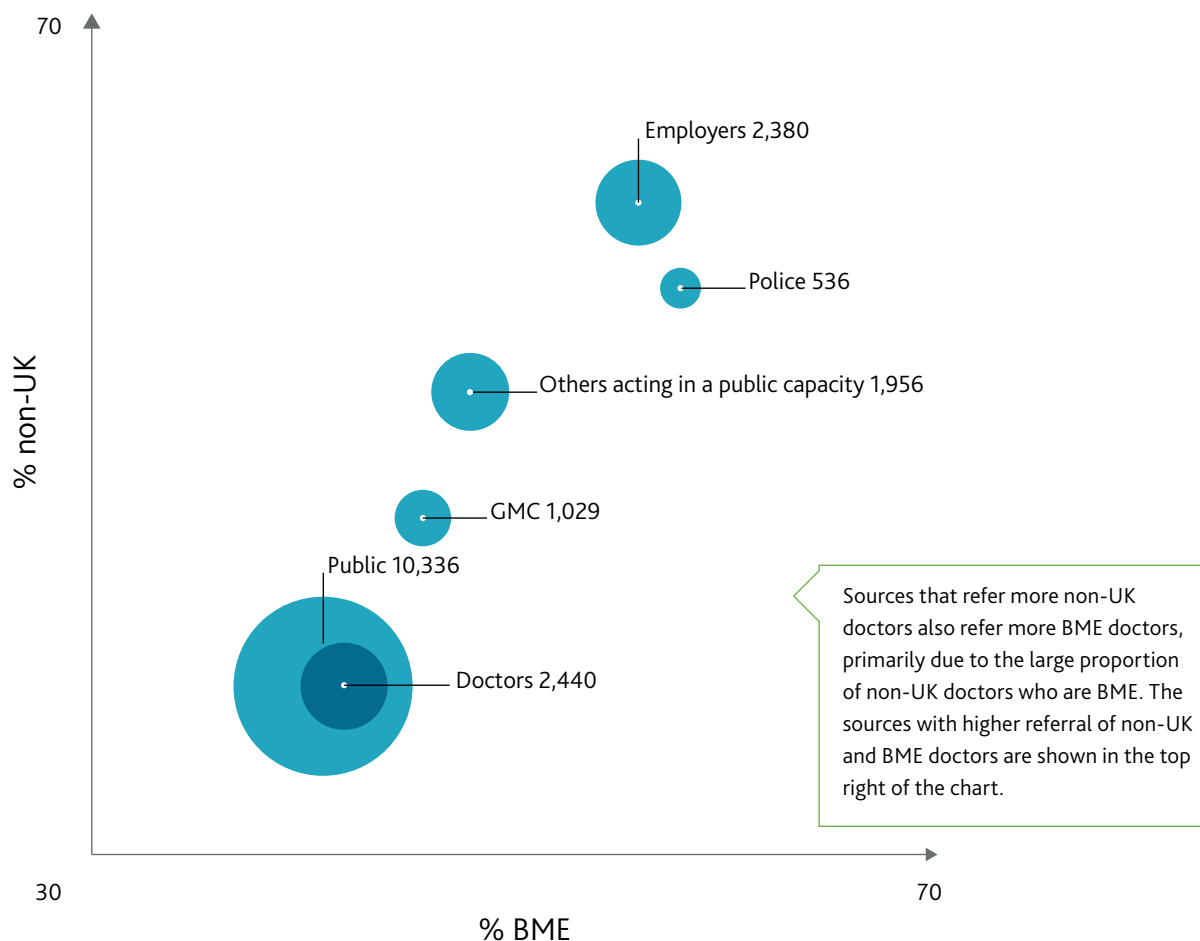
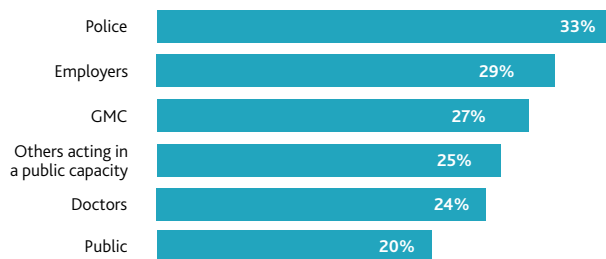


Figure 33: Proportion of UK graduates who are BME in cases arising from concerns raised by different sources in 2010–14*



* 22% of licensed UK graduates were BME in 2014.

In last year's report we noted that BME and non-UK doctors receive proportionally more complaints from employers, and proportionally more criminality cases. This year we have investigated whether the two are linked, and asked if the higher proportion of investigations stemming from employers' concerns about BME and non-UK graduates are a result of employers referring different types of cases in terms of the allegations involved.

The answer is, broadly, that this is not the reason. Some of this analysis is summarised in figures 34, 35, and 36. We have looked at the proportion of cases accounted for by IMGs, EEA graduates and BME doctors. The pattern of proportionally more investigations of these groups stemming from employers is not due to the difference in the types of allegations that employers make because this finding is true across all types of allegations apart from health.

A high proportion of cases resulting from concerns raised by the police involve criminality. The relatively high share of BME doctors in these cases (figure 31, page 71) may in part reflect the higher proportion of BME people in parts of the criminal justice system overall.⁶⁵

Figure 34: Index of the proportion of cases that involve international medical graduate (IMG) doctors relative to the proportion they account for in all cases with the same allegations, 2010–14

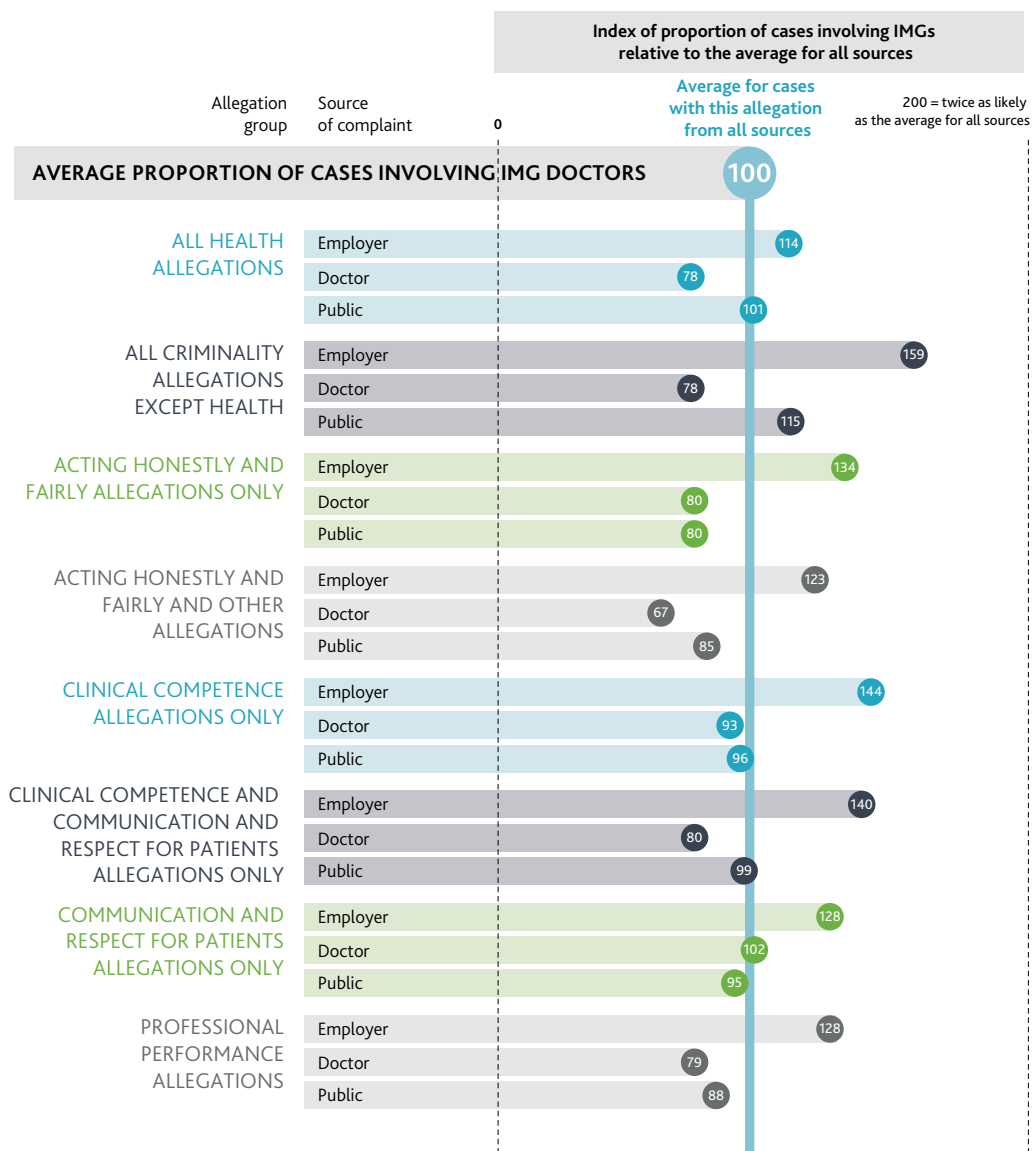


Figure 36: Index of the proportion of cases that involve BME doctors relative to the proportion they account for in all cases with the same allegations, 2010–14

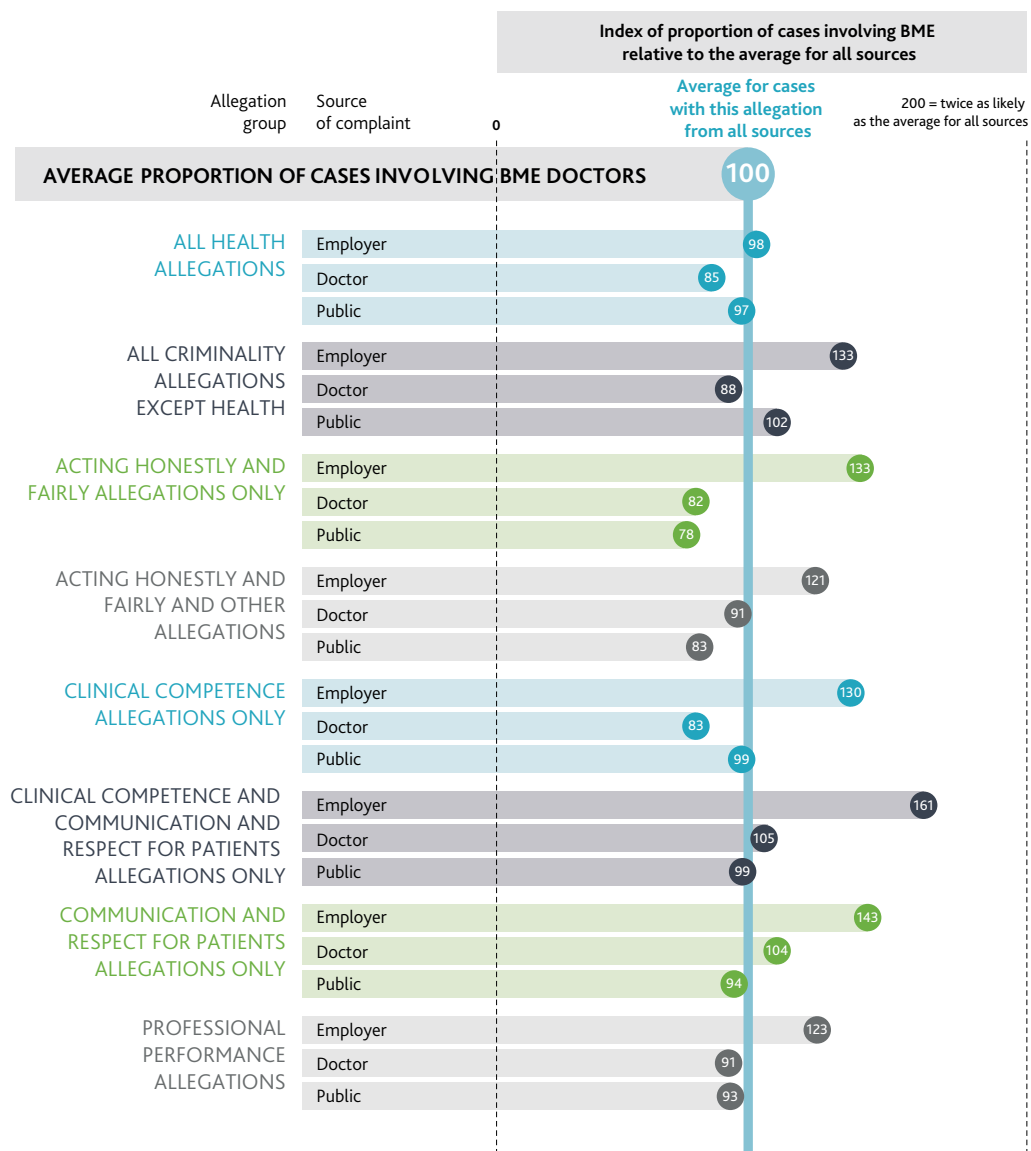
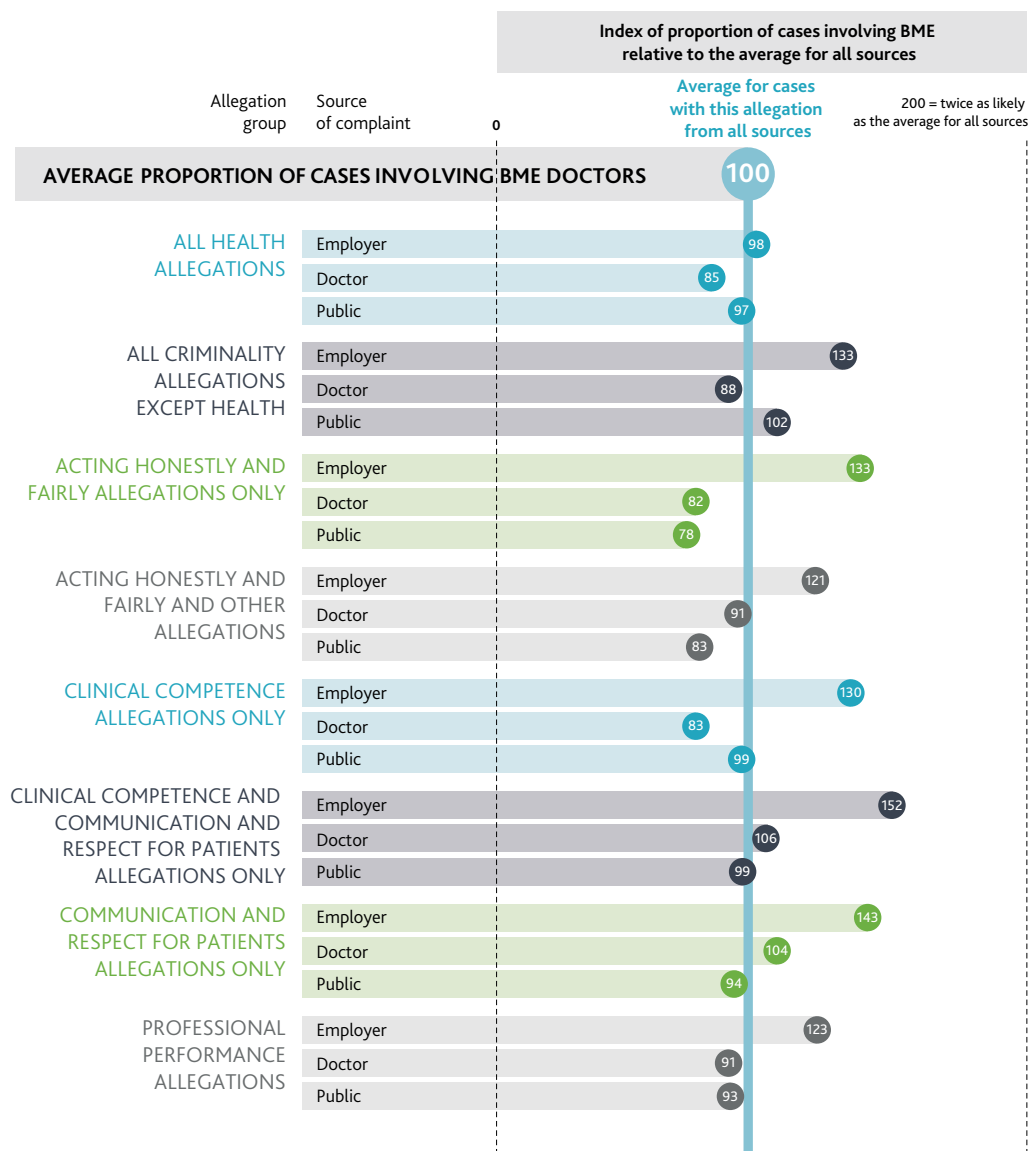


Figure 36: Index of the proportion of cases that involve BME doctors relative to the proportion they account for in all cases with the same allegations, 2010–14



What factors influence how long it takes to resolve a case?

Most cases are resolved in just over six months

The GMC can either resolve cases directly or, in the most serious cases, refer them to the MPTS for a panel hearing. A case resolved directly by the GMC can:

- be closed with no action
- be closed with advice given to the doctor on their practice or behaviour
- be resolved by giving the doctor a formal warning
- be resolved when the doctor accepts their fitness to practise is impaired and agrees to undertakings.

If a case is referred to an MPTS panel hearing and the doctor's fitness to practise is found to be impaired, then the panel can:

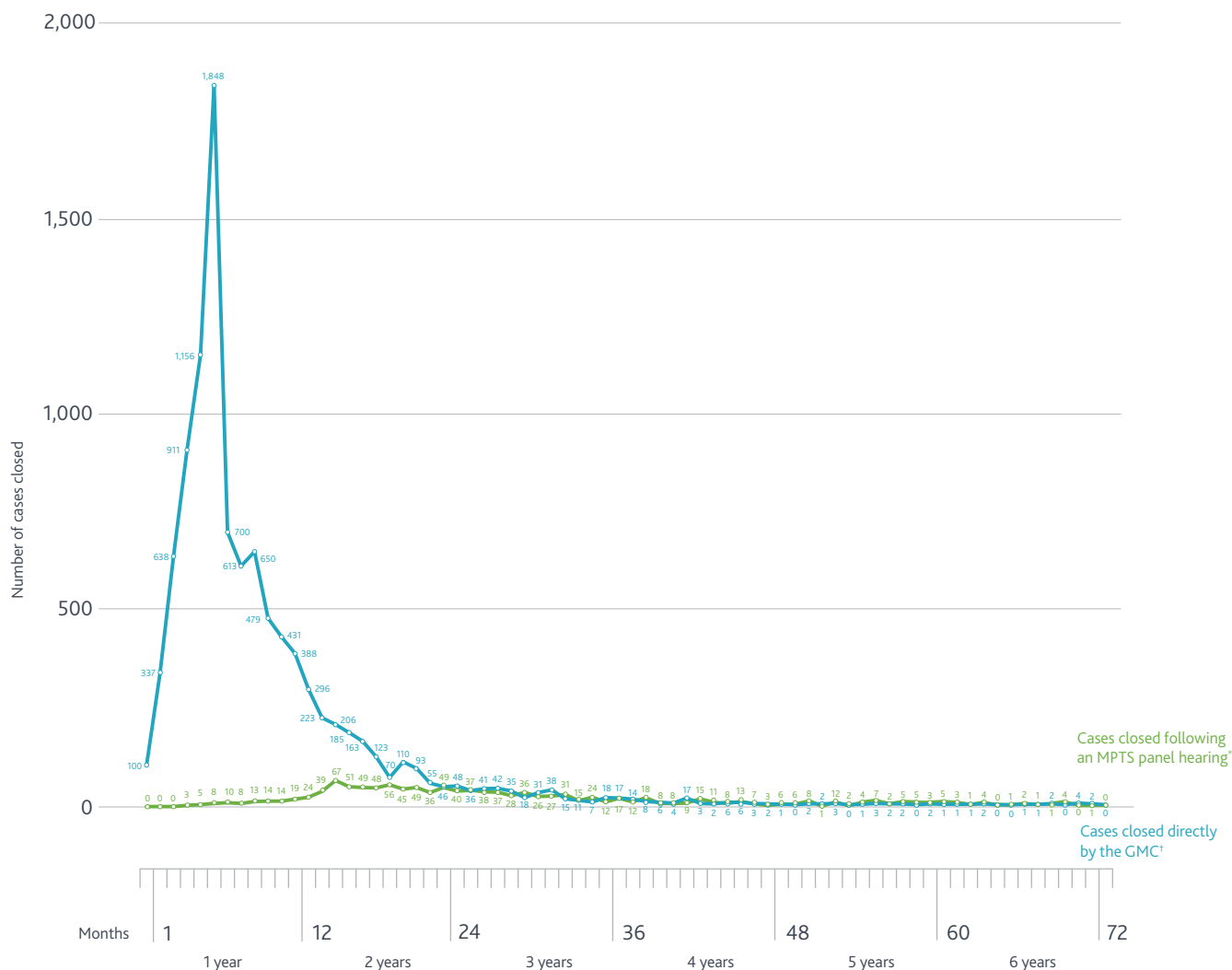
- decide to take no further action
- impose conditions on a doctor's registration
- suspend or erase a doctor from the medical register.

If the doctor's fitness to practise is not found to be impaired, then the panel can decide whether to impose a warning.

46% of the 10,309 cases reaching a closure date which were investigated or referred to employers in 2010–14 without the need for an MPTS panel hearing were closed within six months, and 80% were closed within a year (figure 37, page 80). The median case length was 6.2 months. Of the cases that had a panel hearing, the median length was 27 months and 81% were completed in three years or less.

The data below differ from those found in reports made by the GMC elsewhere, as we look specifically at the median time from the enquiry being received to the doctor being told the outcome of the investigation. In other reports the case may be considered closed only after an appeal period is ended and the doctor does not lodge an appeal, or the time may be measured up to the point at which the GMC's processes end, when the MPTS hearing begins. We also look at the upper and lower deciles of case length to give a top and bottom range, but exclude the more exceptional outliers.

Figure 37: Length of time taken to complete cases, by whether the cases had an MPTS panel hearing or were closed directly by the GMC



* The total number of cases closed after a panel hearing in >72 months were 23.

† The total number of cases closed by a case investigator in >48 months were 59.

Gathering evidence can affect the length of the case

Cases can be delayed while the GMC waits for information or other investigations. For example, the GMC cannot usually progress a case while a criminal investigation into the same matters is ongoing. The GMC is also dependent on the cooperation of outside bodies, such as the NHS, for access to evidence such as medical records. Delay in receiving medical records in secondary care settings adversely affects the progress of cases.

The GMC counts timescales from when we first receive information about a possible concern, even if we then have to wait for outside bodies to complete investigations or independent inquiries.

This analysis looks only at complaints about a doctor's fitness to practise that are investigated or referred to employers. It does not include those cases that are closed immediately and not investigated. For this reason these data may not match exactly other published data.

It is worth noting that more than one case can be heard by the same MPTS hearing – for example, where several similar complaints are made about the same doctor, or new complaints are made during an ongoing investigation.

Over the period 2010–14, where an MPTS hearing handled only one case, the median length was 22 months. For multiple cases at one hearing, the median length was 31 months. About 12% of cases were heard alongside other cases in the same hearing.

Figures 38 and 39 (pages 82–83) show how the length of investigated cases are affected by the outcome as well as whether there was a delay while waiting for a non-GMC investigation to complete. The severity of the outcome affects the length of the case: cases that did not go to an MPTS panel but that ended in a sanction took a median of ten months to be closed by the GMC; cases closed by the GMC with advice or no further action took a median of six months. Cases closed by the GMC and an MPTS panel both took substantially longer if new information was received after six months. This is one of a number of factors that is difficult or impossible to control.

Figure 38: Number and length of cases that were closed without going to an MPTS hearing in 2010–14

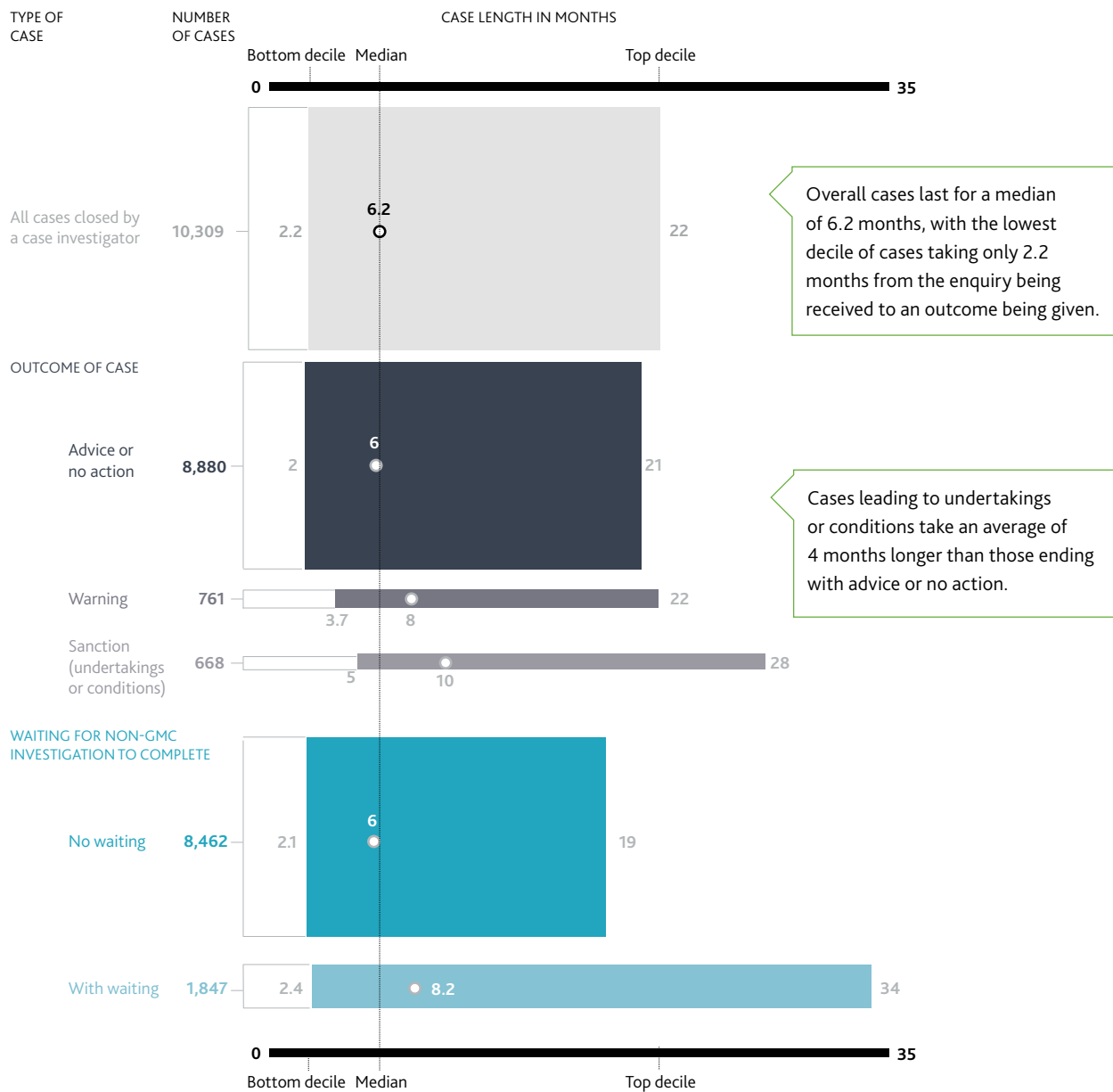
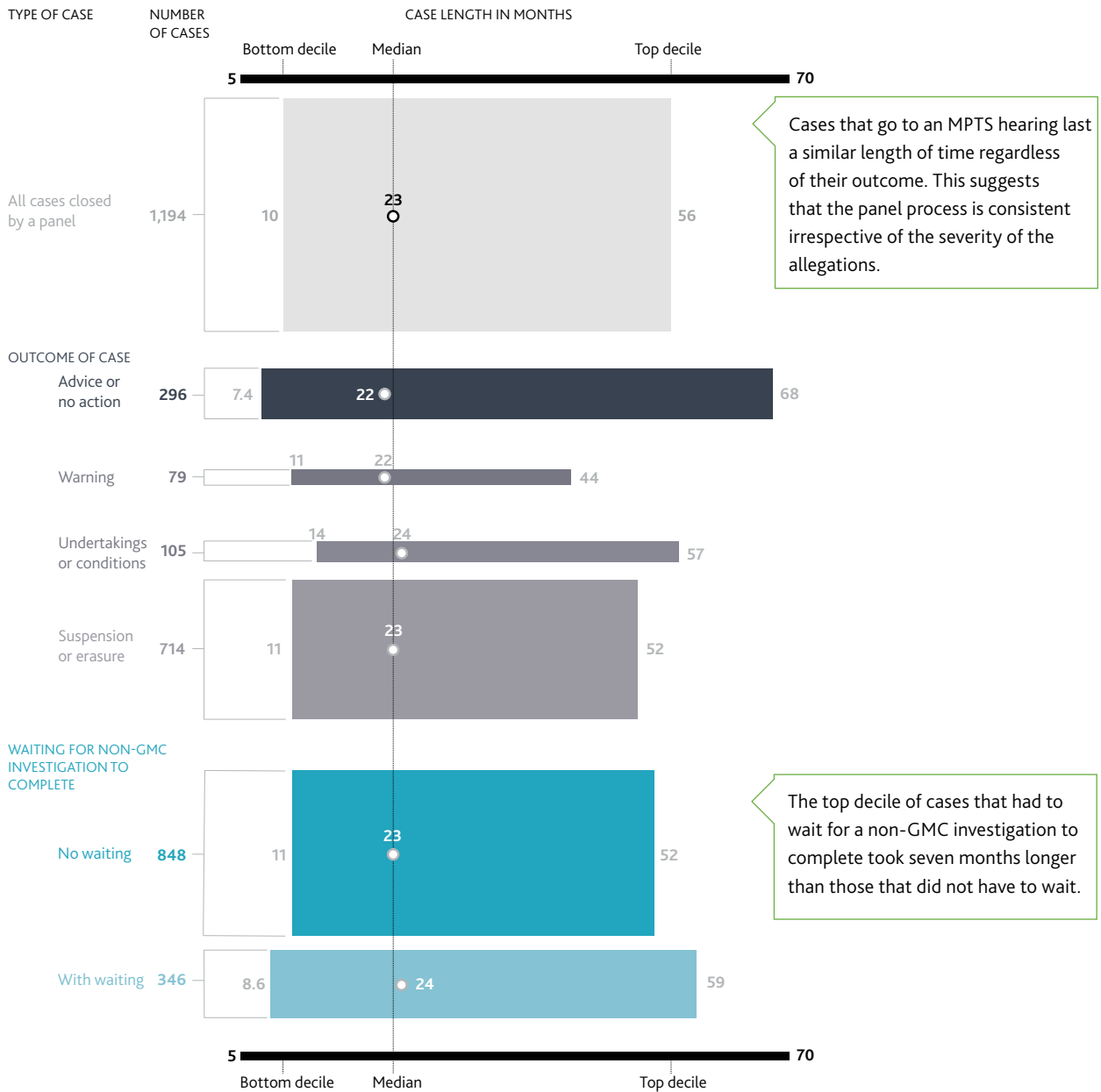


Figure 39: Number and length of cases that were closed following an MPTS hearing in 2010–14



Chapter three:

What can we learn from enquiries about doctors and our standards?

The GMC gathers qualitative intelligence from a number of sources – this is more difficult to interrogate and analyse than the quantitative data, but it may be useful in helping to identify current or future risks to patient safety.

In this chapter, we look at this qualitative intelligence and consider where it can help those responsible for planning, managing or regulating healthcare to understand pressure points in the system, and to assess what action they might take to support doctors and the systems in which they work to tackle any deficits and deliver a good standard of care.

We have categorised these sources of intelligence into two forms – proactive and responsive.

It should be noted that the numbers of both proactive and responsive enquiries to the GMC are relatively small when set against the number of patient interactions with doctors every day in the UK's healthcare system. We need to be careful therefore not to overstate or ascribe too much meaning to these data. In some cases though, it may be indicative of an underlying concern, or a trend, or a more fundamental issue that requires further investigation.

Proactive enquiries

Doctors and medical students contact the GMC for advice on a wide range of issues, including how they should apply the GMC's guidance in practice. The GMC also receives queries from patients, relatives and other interested groups about the standards set in the GMC's guidance, the care they should expect, and a host of specific ethical issues.

These enquiries reach the GMC through a number of channels (box 1, page 86): the standards and ethics advice service, the teams in Northern Ireland, Scotland and Wales, the regional liaison service (RLS), the confidential helpline, the contact centre, and the education quality assurance team. In this chapter, we use 2014 data from these sources.

These enquiries can signal that the GMC, employers or others may need to raise the profile of particular issues or to improve the guidance and support available.

Responsive enquiries

Responsive enquiries arise when there are concerns as to whether a doctor or doctors have followed good practice. Again this can come from medical students, doctors, employers or members of the public. Some of these enquiries come through the same channels as proactive enquiries, but most come in the form of a complaint about an individual doctor.

Chapter 2 discusses complaints about doctors that come through fitness to practise channels in greater detail.

Responsive enquiries can signal areas where doctors may need more support to meet the standards expected of them.

BOX 1: Sources of qualitative intelligence**The GMC standards and ethics advice service**

This service offers advice on how doctors should address an ethical dilemma or challenging situation in a way that is consistent with the GMC's *Good medical practice* and explanatory guidance.⁶⁶ In 2014, the service received 564 enquiries, of which 295 were proactive enquiries and 41 were responsive enquiries raising a concern that doctors had failed to meet the standards expected of them.*

The teams in Northern Ireland, Scotland and Wales

The teams in the devolved offices promote GMC guidance through workshops and other events for doctors, medical students and patient groups as well as others working in this area. As part of this, they gather feedback on what concerns those on the front line, as well as topics on which they want advice.

The Regional Liaison Service in England

On a daily basis, Regional Liaison Advisers meet patients, doctors, medical students and medical educators to explain the GMC's role, including how its guidance and standards should apply in practice. They also gather feedback on what is happening on the ground and this includes asking for feedback from workshop participants.

The confidential helpline

The GMC confidential helpline is one of a number of routes by which doctors and others can raise concerns. It was set up in late 2012 to

enable doctors to seek advice and to raise serious concerns about patient safety when they feel unable or unsure how to do this at local level.⁶⁷ There were 586 calls to the helpline in 2014, most of which were about doctors' fitness to practise or failure to follow GMC standards. Only 150 enquiries had enough detail recorded to understand the nature of the enquiry.[†]

The education quality assurance team

The team analyses information from a range of sources. The team visits and takes part in inspections of hospitals and GP surgeries where doctors practise. As part of this they gather feedback from staff, students and doctors in training, as well as carrying out formal surveys of doctors' experiences of these training environments.

The team also works with a range of organisations to improve the quality of medical education and training through a process of enhanced monitoring. This occurs when there is concern about the training of medical students or doctors, which has not improved sufficiently despite attempts to collaborate with those responsible, and the GMC believes this could adversely affect patient safety, doctors' progress in training, or the quality of the training environment. In addition to concerns raised through the enhanced monitoring process,⁶⁸ we have also analysed the issues raised by medical royal colleges and faculties through their annual reports to the GMC.[‡]

* The remaining 228 enquiries did not contain enough information to establish the subject, should have been directed to other regulatory organisations, asked for non-specific advice (ie where to locate the advice section of the GMC website) or for official GMC positions or statements on particular subjects, or were employer-related issues or unrelated to doctors' activities.

† 351 enquiries did not capture enough detail to fully establish the subject, of which 209 were concerns about doctors' fitness to practise that would have been referred to the relevant team and counted there. The remaining 85 enquiries had identifiable topics but were not relevant to this analysis.

‡ Data from the formal surveys of doctors' training environments are used in chapter 4 where we look at a case study of trust performance in England.

Proactive enquiries to the GMC

From the activity of GMC staff and liaison teams across the UK, we can identify issues that doctors and medical students appear to be most interested in (box 2).

In 2014, there were three areas which stood out in terms of doctors seeking further information or advice:

- prescribing*
- confidentiality, including the risks from new technology
- end of life care.

BOX 2: What do our key interest groups in Northern Ireland, Scotland, and Wales want advice on?

In 2014, in Northern Ireland, the most popular sessions asked for were about confidentiality, revalidation, maintaining boundaries with patients, continual professional development and acting as an expert witness. Doctors in training asked for sessions about consent, confidentiality, personal beliefs, maintaining boundaries with patients, and reporting convictions.

In Wales medical students in their first, second and third years asked for sessions about end of life care, advice on delivering care to those aged 0–18 years, protecting children and young people, conflicts of interest and prescribing.

In Scotland medical students expressed interest in similar issues, particularly prescribing and personal beliefs. Other events drew enquiries about informed consent, raising concerns, end of life treatment and care, and good medical practice.

* *Good practice in prescribing and managing medicines and devices*³⁷ was updated in 2013. It builds on the principles set out in *Good medical practice*, but does not advise on which medicines or devices to prescribe for particular conditions.

There is strong interest in advice and support on prescribing practice

Unsurprisingly, there is continuing interest in acquiring and maintaining the knowledge and skills for safe and appropriate prescribing.

In their enquiries to the GMC, doctors raised a range of questions.

- Who takes responsibility for checking prescriptions to make sure that medicines are safe and appropriate in environments where a patient may be assessed, treated and monitored by multiple doctors or other healthcare professionals?
- When is it appropriate to use new, imported or unlicensed medicines?
- What should I do when a patient asks for a particular drug and disagrees with my view that the drug should not be prescribed?
- What do I need to consider when prescribing for patients in other countries?
- Can I prescribe a cheaper but unlicensed medicine instead of the licensed alternative?

The GMC published updated guidance on prescribing in 2013.⁶⁹ The publicity and subsequent promotional work may have led to increased interest in clarifying the expected standards for prescribing. In 2014, 100 doctors fed back to the RLS that they would be interested in attending a workshop on good practice in prescribing and managing medicines – this was their fifth most common request. In 2013, this topic was not in the top five topics raised by doctors, although it was the most requested by medical students.⁵⁷

Research on the prevalence and causes of prescribing errors shows that this is an ongoing concern, and shows that many prescribing errors involve doctors in training who do most of the prescribing in secondary care^{70,71} as well as GPs.⁷²

National organisations have made prescribing errors a priority in recent years. For example, the British Pharmacological Society and Medical Schools Council Assessment set up a website to allow medical students to demonstrate their competence at prescribing.⁷³ Last year, The Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England issued a patient safety alert to improve reporting of and learning from medication errors,⁷⁴ and the Health Foundation produced an evidence review of ways to tackle prescribing errors.⁷⁵ The Welsh Government,⁷⁶ the Scottish Patient Safety Programme⁷⁷ and Northern Ireland's Regulation and Quality Improvement Authority are all promoting better prescribing.⁷⁸ This may also have prompted doctors to seek advice from us and other sources.

Doctors are concerned about patients' confidentiality

The perennial tension between confidentiality and appropriate sharing of information continues to provoke interest and concern among front-line practitioners. The digital revolution which has brought so many advantages in terms of access and speed of transfer of patient data has also raised a host of ethical questions and added further complexity. Balancing competing interests, especially in sensitive areas, such as child protection and fitness of patients to drive, can present practitioners with difficult decisions, sometimes with no single right answer.

The GMC's standards and ethics advice service will only come across a tiny fraction of the dilemmas faced by doctors in everyday clinical practice, but the issues raised about confidentiality illustrate the range of issues doctors face as they grapple with these challenges.

Enquiries in 2014 to the standards and ethics advice team covered topics such as:

- disclosing medical data to family members and whether to do so in sensitive situations (for example, when the patient has a sexually transmitted disease)
- sharing information with medical colleagues who are not involved in the patient's treatment, with administrative staff or with external organisations (for example, medical insurance companies)
- what information can be shared as part of legal processes (for example, court hearings)
- keeping data secure and controlling access to medical records
- how to deal with accidental disclosure of information through insufficiently secured medical records or correspondence.

In 2014, the Regional Liaison team in England received 86 requests for sessions on confidentiality and ran 34 workshops on this issue. The Northern Ireland office asked doctors to suggest workshop topics they felt would be useful – this was the second most-requested workshop from doctors in training. The GMC's web pages which offer guidance on confidentiality issues received 64,572 hits in 2014. This was the second most-popular guidance section on the GMC's website for that year.

The wide variety of confidentiality issues raised through different channels suggests that there may be significant demand for advice, training and other practical support.

Developments such as new technology, or laws such as the new duty for all health and social care professionals to report cases of female genital mutilation in England and Wales, changing public expectations about privacy, and widespread media coverage about patient confidentiality are all likely to lead to doctors facing questions from patients and having questions of their own.

Recent high-profile media events^{79,80} have highlighted the delicate balance between maintaining confidentiality and ensuring public safety. This is likely to be of some concern to doctors, and it is clear that there are difficult decisions to be made around the sharing of patient data where the public is at risk. GMC guidance currently offers specific advice on when it is appropriate to disclose medical information to the DVLA or DVA, where a doctor has concerns about a patient's fitness to drive and the safety of the public.⁸¹

Next year the GMC will update and reissue its guidance on confidentiality and will develop further resources and training materials.

Doctors are concerned about risks arising from the spread of new technology

There is evidence that doctors are concerned about the implications of developments in the use of new technology. Most of the enquiries to the GMC concern the impact of telehealth, and the risk of sharing information inappropriately through the personal use of social media platforms.

The impact of telehealth

Telehealth (delivering medical care at a distance using communication technologies) is quickly becoming an established feature of modern healthcare delivery.⁸² There have been numerous studies on the benefits, including one trial that found that telehealth can reduce both hospital admissions and patient mortality.⁸³ There are now initiatives across the UK looking at how to expand and extend the use of telehealth.^{84, 85, 86, 87}

The Medicines and Healthcare Products Regulatory Agency is concerned about online prescribing, and from July 2015 anyone in the UK selling medicines online to the general public has to be registered with them and display the approved logo.⁸⁸

Providing good end of life care

This continues to be an important issue politically, socially and in the media.^{89, 90, 91, 92, 93, 94} The GMC published updated guidance on end of life care in 2010,⁹⁵ along with a range of resources with other organisations to support doctors and multidisciplinary teams.⁹⁶ In last year's report we looked at the issues around the abolition of the Liverpool Care Pathway,⁵⁷ which was used to plan care for people in the last few days and hours of life. In the summer of 2014, the Leadership Alliance for the Care of Dying People released its report on how to approach end of life care⁹¹ but there have also been concerns voiced that end of life care is not seeing enough investment to be fully effective⁹⁶ with the Health Service Ombudsman criticising end of life care in many areas in the recent *Dying without dignity* report.⁹⁷

Some doctors have warned that existing care homes are not set up to cope with modern palliative care, at a time when the need for it is increasing.⁹⁸ Professionals and campaign groups working in this area believe it is important to give people the choice of where to die, and that this can be achieved with better planning, more support for carers, and health and social care professionals cooperating in a coordinated way.⁹⁹ Healthcare organisations are aware that the ageing population means there will be increasing numbers of people with long-term conditions that require medical treatment over the next two decades.¹⁰⁰ This will be combined with a rising death rate (projected by the Department of Health to increase 17% between 2012 and 2030¹⁰⁰) to increase pressures on end of life services. It is not certain what impact this will have on end of life care at this time.

Doctors are expected to respect patients' decisions, which can include their wish to die at home rather than in a hospital – but relatively few people have made their preferences clear to their doctors or their family. A recent UK-wide study of 1,972 members of the public found that only 4% of people had recorded a written preference for their end of life care, but only 7% wanted a doctor to decide their treatment if they became unable to communicate or make a decision for themselves. 52% of people stated they preferred to make their own decisions in advance, and 30% preferred a partner or family member to make the decisions.¹⁰¹

Again, the number of direct enquiries received by the GMC on this topic is small, but it is clearly an area of continuing interest and concern for many doctors. Last year, 105 doctors asked the RLS for workshops on delivering good quality end of life care while the standards and ethics advice service received enquiries about a range of end of life topics, including queries about deciding whether to resuscitate a patient, and how doctors should respond to patients who want to end their own lives. The GMC's web pages which offer guidance on end of life care received 24,834 hits in 2014.

Responsive enquiries: concerns raised about failure to meet standards

The most common topics raised by calls to the GMC's confidential helpline (box 3) and contact centre, where doctors appear to have fallen short of the standards expected of them, are:

- doctors bullying and undermining other doctors and healthcare professionals or being bullied and undermined by them
- mental and physical health problems in doctors.

The GMC offers advice and guidance on both of these topics, though there are many other places that doctors can get advice or guidance, and raise concerns – including with their employer, the British Medical Association (BMA), medical defence organisations and medical royal colleges. It is important to stress therefore that the GMC's qualitative data are a small part of this wider picture. Nevertheless, the GMC's web pages on raising concerns received 15,202 hits in 2014, suggesting an interest from doctors in how and where to raise concerns about their working environment. The types of issues raised are likely to be within the power of employers and others to intervene and prevent, as has been reported in the GMC's national training survey bullying and undermining report.¹⁰²

BOX 3: What enquiries do we receive through the confidential helpline?

The confidential helpline received 586 calls in 2014. Of these 150 had sufficient detail recorded about the topic and these are the basis of analysis in this chapter.

135 enquiries were reporting doctors for failing to meet professional standards, often because of poor clinical performance, bullying and undermining behaviour, or failure to act honestly. Many of these enquiries were from doctors or employers, although some were from other healthcare professionals or the public.

15 enquiries were from doctors who wanted advice on how to provide good quality care.

Bullying and undermining continue to be a problem

Over the past two years, there has been heightened awareness about bullying in the NHS.¹⁰³ The 2014 NHS England staff survey found that almost one in four staff said that they experienced harassment, bullying or abuse from their manager or other colleagues.¹⁰⁴

This has coincided with growing interest in allegations that staff who do raise concerns can find themselves pilloried and victimised by both colleagues and managers.^{103, 105, 106, 107}

It is possible that this raised profile, exacerbated by the debates following the Mid Staffordshire inquiry³⁰ is encouraging more doctors to draw attention to undermining behaviour and to be less tolerant when they see it. The GMC's 2014 national training survey found that 8% of doctors in training had experienced bullying and 14% had witnessed it.

Nearly one in five of the 150 confidential helpline calls analysed were about serious problems in working relationships between doctors. About three-quarters of these were linked to bullying or undermining in various forms. The education quality assurance team also found problems with bullying and undermining at six of the 23 sites that required enhanced monitoring in 2014. In many cases, the education team found that consultants were not aware that doctors in training regarded their actions as undermining. When made aware of this, they were prepared to change their behaviour.⁴⁴

This difference of perception, where one side sees firm management and another sees bullying, was also raised when the GMC consulted on proposed changes to the sanctions guidance.*¹⁰⁸ Respondents to the consultation also highlighted the importance of tackling and properly investigating bullying, especially when it involves doctors who are whistleblowers. These issues suggest that healthcare organisations – such as employers, regulators and doctors' representatives – need to work together and with doctors to handle bullying carefully.

Action to tackle bullying and undermining

The GMC's 2015 review – *Building a supportive environment: a review to tackle undermining and bullying in medical education and training* – found that many medical students and doctors who have experienced bullying find it hard to speak up.⁴⁴

The GMC's experience is that even when doctors try to resolve problems with working relationships or instances of bullying by working with their employers or local bodies, this can cause a further deterioration in relationships. Moreover, data from the national training survey show that doctors in training are often reluctant to speak out about bullying, fearing reprisals and with no confidence that their concerns will be addressed.¹⁰²

* The Medical Practitioners Tribunal Service (MPTS) fitness to practise panels use the sanctions guidance¹⁰⁹ to decide what action to take against doctors whose fitness to practise is impaired.

Doctors and other healthcare professionals at all levels and in all environments have a right to work free from bullying and undermining. Regulators have a role to play in tackling this behaviour, particularly when healthcare professionals feel that their concerns have not been addressed locally or that they cannot raise concerns locally. Doctors may raise concerns with the GMC because they see it as a safer option.

In June 2015, the GMC and the Nursing and Midwifery Council issued joint guidance for doctors, nurses and midwives on their duty of candour – a professional responsibility to be honest with patients when things go wrong.³⁸ This guidance was developed following the inquiry into events at Mid Staffordshire NHS Foundation Trust, which showed that healthcare professionals did not feel supported by their employers to meet their duty of candour. In England, the Care Quality Commission will regulate organisations' compliance with a statutory duty of candour, and the governments in Northern Ireland, Scotland and Wales are developing their own plans for implementation. It is intended that encouraging a culture of openness, where doctors feel able to raise concerns about others and speak with candour about their own practice, will make it easier for doctors to report any bullying and undermining that they have experienced or witnessed.⁴⁵

Helping doctors with mental and physical health problems

Many doctors may suffer ill health during their careers, but in most cases this will not affect their fitness to practise. They are able to manage their conditions effectively, and the quality of care they deliver is not impaired.

However, in some cases, illness can negatively affect the care a doctor delivers, which can put patients at risk.

Doctors may be more vulnerable to mental health problems than the general population,¹¹⁰ particularly female doctors.¹¹¹ A higher proportion of doctors experience social dysfunction, fatigue, depression and substance abuse than the general population.^{112, 113} 10–20% of doctors become depressed at some point in their careers and they have a higher risk of suicide than the general population.¹¹⁴

About one in seven of the 150 confidential helpline calls analysed were about other doctors' substance abuse or mental health or physical health problems potentially impinging on their practice. However, the proportion of all fitness to practise complaints made to the GMC that relate to a doctor's health is much lower – just 6% of cases.

Research suggests that doctors in general tend to minimise their own health problems, do not take time off work, have a poor understanding and distrust of occupational health services and tend to self-diagnose and self-prescribe.¹¹¹ They are aware of how to hide illness and may want to do so because of the stigmas attached.¹¹⁵

Data on the frequency of enquiries about doctors' health can help the GMC and employers show doctors with health conditions that they are not isolated. The GMC and employers understand that health issues are common and must be addressed appropriately before doctors' practice becomes impaired. If doctors do so, they will usually be able to continue practising. In 2014, 22 doctors were given a sanction by a fitness to practise panel because they had not addressed their health problem and it affected their fitness to practise.

Issues raised by medical educators

Concerns raised by medical royal colleges and faculties

The medical royal colleges and faculties submit annual specialty reports to the GMC. These provide an oversight of the quality of training, highlight areas of good practice, and comment on developments in the specialty.

Feedback from the 2015 reports reveal that service pressures are having an impact on education and training in a range of ways. The themes raised have remained consistent in recent years and it is fair to say that the 2014 reports covered the same concerns. The reports do not provide enough evidence to gauge the depth or consequence of concerns, but the situation as described is certainly not improving. More research is needed to establish how far service pressures are damaging postgraduate education and, if so, what action needs to be taken to deal with it.

One measure which echoes what the medical educators are saying and which may reflect some of this pressure is the increasing number of organisations that are subject to enhanced monitoring (see box 1 on page 86). Enhanced monitoring was introduced at the start of 2012 with a handful of organisations under surveillance. In June 2012 the number of sites under enhanced monitoring was 23, and by September 2015 it had risen to 89. To some extent this may be the result of extra vigilance by the GMC and local bodies but the GMC's resulting quality assurance work certainly suggests that more often than not the educational challenges are linked to service pressures.

In particular the reports highlight the following challenges in the current system.

Job planning: there is a lack of dedicated time in many educational supervisors' job plans to support doctors in training. The colleges argue that if doctors in training do not receive appropriate support, the quality of their education and patient safety could be at risk. This is a view that the GMC would endorse.

Organising assessment: recruiting senior doctors to act as examiners is proving increasingly difficult. As a result examinations are having to be reorganised. There are also problems filling roles essential to training and a lack of locations in trusts to hold examinations.

Staffing levels: some specialties have trouble filling all their training posts. This results in rotas having to be filled by other doctors. This may impact on the quality of education, with doctors in training having to focus on routine work, at the expense of acquiring new skills and knowledge.

The independent sector is restricting training in some key skills: some medical royal colleges have expressed concerns that the transfer of some service contracts to the independent sector has reduced opportunities for doctors in training. This is an emerging issue, and the colleges have suggested it will become more acute unless contracts with independent providers include provision for training. The GMC does not have any firm evidence to support this, but it is a matter that will need to be kept under review.

Issues in training environments that require enhanced monitoring

In 2014, the GMC identified new training and education issues in 32 trusts and GP surgeries to the extent that they were subject to enhanced monitoring (see box 1, on page 86, for more information about the enhanced monitoring process). The most commonly reported themes in these sites concerned:

- poor access to education
- clinical supervision on weekdays or out of hours.

The difficulties were mostly focused on the quality of clinical supervision and access to high-quality training opportunities. This was combined with the detrimental effects on patients arising from doctors not receiving appropriate training. There were also three sites where bullying or undermining was serious enough to require intervention. The vast majority of sites had more than one theme. Only seven training environments had one theme, indicating that problems are often interconnected and require coordinated intervention to unpick.

Verified enhanced monitoring data are available on the GMC website.¹¹⁶

Enhanced monitoring theme	Occurrences
Clinical supervision (weekdays)	11
Poor access to education	11
Clinical supervision (out of hours)	10
Workload or work intensity	9
Staff behaviour	8
Educational governance	6
Handover	3
Rota issues	3
Trainee safety	2
Induction	1
Total	64

What types of cases ended in suspension or erasure in 2014?

The number of doctors erased or suspended every year is very small – less than two hundred out of a register with more than a quarter of a million practitioners. As the cases discussed in this section illustrate, those who are subject to the most serious sanctions have either placed patients at serious risk or undermined the fundamental trust in the profession or in some cases both.

In 2014, only 2% of concerns raised about a doctor's professional standards led to the doctor being suspended or erased from the medical register (157 suspensions or erasures were issued in 2014, there were 8,884 complaints closed that year).

We commissioned an independent review* of 119 MPTS hearings that ended in suspension or erasure in 2014 to understand the types of issues that led to these serious sanctions (figure 40). The review excluded cases in which the doctor's health was an issue.

The 119 cases were referred from a range of sources:

- 36% from the doctors' employers
- 13% from another doctor
- 11% from the police
- 8% from members of the public

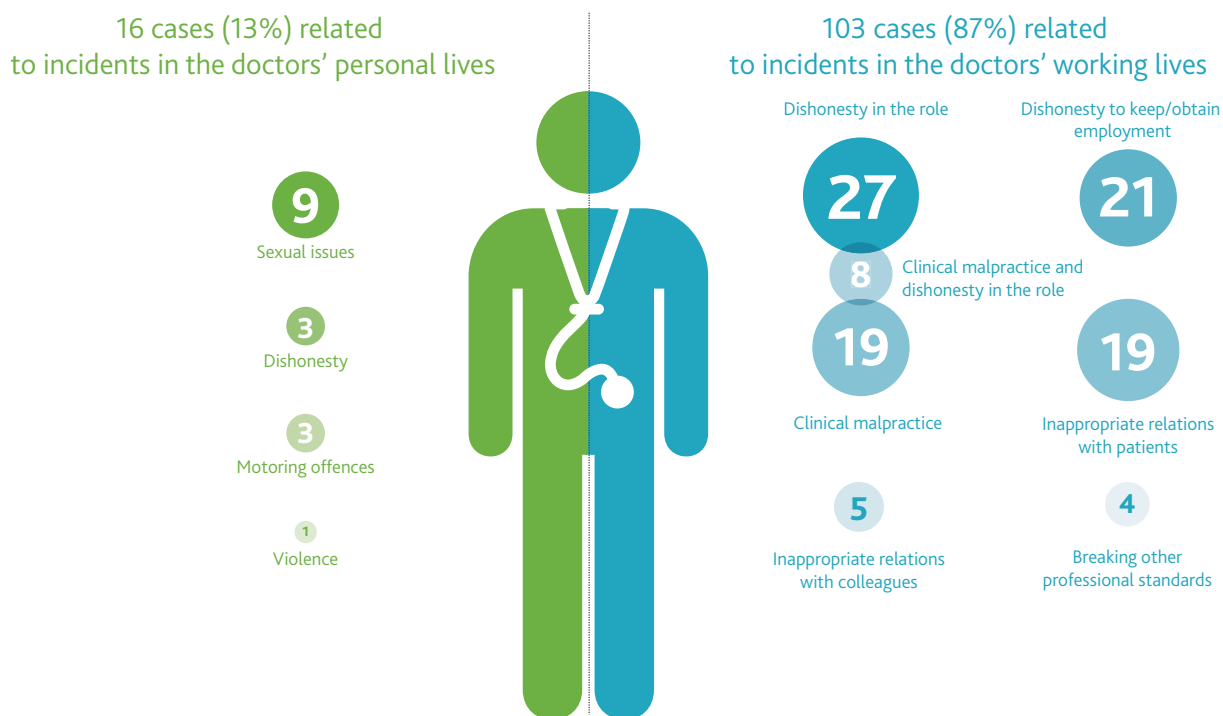
- 8% from the GMC, for example after a media story
- 24% from other groups.

These cases fell into a number of broad categories: dishonesty to obtain or retain a job as a doctor; dishonesty in their role as a doctor, clinical incompetence, poor relationships in the workplace and inappropriate behaviour in their personal lives.

In the case studies that follow, the doctors are referred to as male, but while 98 of the cases involved male doctors, 21 were about female doctors.

* The GMC commissioned independent consultants DJS Research to determine the various factors involved, the different types of cases and whether there were any patterns in these cases when examined in detail and qualitatively.¹¹⁷

Figure 40: Types of issues involved in 119 cases that led to suspension or erasure in 2014



Being dishonest to get or maintain a job as a doctor

Outside the medical profession, lying or exaggerating to obtain a job is apparently acceptable to a minority,¹¹⁸ and there have been suggestions that it is not treated particularly seriously by the media.¹¹⁹

However, there is an important distinction between changing dates of employment or lying about possessing a skill or qualification in many other occupations, and doing so on an application to take up a medical role. The doctor who misleads about possessing an essential skill could place patients' lives at risk, and damage trust in the profession, as in the case study in box 4.

BOX 4: Case study: falsifying a reference

A specialist in training was referred to the GMC after he was convicted in a criminal court of giving a false reference for himself. He was caught because a colleague was concerned about his clinical performance during a locum shift, and so took steps to verify the doctor's references.

The doctor admitted he had created the reference himself as well as the email address that it was sent from.

The MPTS panel took into account distressing family issues and the doctor's evidence of remorse but pointed out that it is difficult for a doctor to demonstrate that they have remediated in cases involving dishonesty. In particular, there was little evidence of insight in this case, other than the doctor's remorse, which gave limited assurance that the behaviour would not be repeated.

Outcome: the doctor was suspended for 12 months

The MPTS panel concluded that the doctor's fitness to practise was impaired due to his conviction, and that falsifying documents relating directly to clinical practice put patients at risk and brought the reputation of the medical profession into disrepute.

Failing to maintain standards through dishonest prescribing

Ten cases involved dishonesty in prescribing. In the case study in box 5, the doctor had been falsifying prescriptions over a long period, showing dishonesty and an ongoing failure to meet expected standards. Dishonesty involving prescriptions can also result in a criminal conviction, as in this case where the doctor was found guilty of both theft and forgery.

BOX 5: Case study: obtaining prescriptions dishonestly

A doctor working at a hospital was referred to the GMC after being convicted of fraudulently obtaining prescription-only medicines.

Over a period of eight months, he stole nine prescriptions, some of which he forged in the names of non-existent patients and non-existent prescribing doctors. He presented some of them at various community pharmacies to obtain medicines fraudulently.

The doctor said he had stolen the prescriptions to treat his own medical condition. He described his actions as a 'stupid mistake' and a 'one-off'. The panel concluded that despite some evidence of insight, his premeditated and prolonged behaviour indicated an underlying attitude problem that was fundamentally incompatible with being a doctor.

Outcome: the doctor was erased from the medical register

The MPTS panel concluded that his fitness to practise was impaired due to his conviction.

Failing to maintain standards through poor clinical competence

Doctors need to keep their skills up-to-date and make sure they are practising to the standards needed to deliver safe, effective care to patients. As well as maintaining high standards in their own practice, the GMC expects doctors to be prepared to protect patients from poor care by tackling concerns about the skills and competence of the doctors and other healthcare professionals they work with.

The public expects high standards from the medical profession and increasingly they also

expect their doctors to take responsibility for the wider service and to tackle problems when and where they see them. This has probably been exacerbated by high-profile failures to provide adequate care, such as those exposed by the Bristol and Mid Staffordshire inquiries.^{31, 32}

In the case study in box 6 the doctor failed to perform the basic requirements and the problem arose because of poor clinical performance.

In addition, the doctor showed a lack of insight and failed to take responsibility. The doctor's refusal to acknowledge fault placed a serious question mark over his ability to reflect on his performance.

BOX 6: Case study: failure to provide good quality care

A doctor was investigated by the GMC for failing to provide good clinical care to a patient following routine knee surgery. During the transfer from the operating theatre to the recovery area, the patient's condition rapidly deteriorated. The doctor in the operating department found she did not have a pulse, called for assistance from the crash team and started CPR.

The panel said the anaesthetist did not observe the patient appropriately and failed to establish that she was physiologically stable before attempting a handover. After the doctor in the operating department intervened, he did not exert the professional command expected of his position.

He denied his treatment was below standard, stating that he would not have done anything differently. The panel found that the doctor lacked insight and a willingness to reflect on and learn from the event. There was no evidence of concern or regret about the serious extent to which he had compromised the patient's life, and the panel concluded that he had deeply ingrained attitude problems.

Outcome: the doctor was erased from the medical register

The MPTS panel said that the acts and omissions of the doctor led to a situation in which a patient's life might have been at risk and that the outcome would have been very different had it not been for the attention she received from other healthcare professionals. The panel concluded that the care the doctor provided fell seriously below the standard expected of a reasonably competent doctor.

Failing to maintain standards through relationships in the workplace

The GMC's *Good medical practice* states that doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to the patient.

Relationships with patients must be professional and appropriate, even if the patient wants the doctor to act beyond boundaries.

In the case study in box, it did not matter that the doctor did not have any bad intentions: the actions were inappropriate with a negative impact on the patient, and put the reputation of the medical profession at risk.

BOX 7: Case study: inappropriate sexual relations with a patient

A doctor who had worked as a GP for many years, was referred to the GMC after visiting a patient's home and engaging in sexual activity with her.

The doctor claimed that he had visited the patient to deliver a letter, and that the sexual activity was sudden and unanticipated. When he realised that what he was doing was wrong, he immediately stopped. In addition, he insisted he had not previously made any inappropriate advances to any patient.

The doctor immediately admitted and accepted responsibility for his actions when interviewed by the police. The doctor made it clear throughout the hearing that he did not seek to minimise the gravity of what he had done by attaching any blame to the patient, and agreed that his actions had brought the medical profession into disrepute.

The panel considered the doctor's insight and acceptance of what he had done wrong, and his honesty throughout the process. They also considered evidence from the doctor's two adult children that he was under various personal stresses at the time of the incident. Although this evidence was not independent, the panel accepted the credibility of the witnesses and was satisfied with the measures the doctor had since put in place to alleviate his stress.

Outcome: the doctor was suspended for 12 months

The GMC submitted that the doctor should be erased from the medical register due to the severity of his misconduct. However, the MPTS panel accepted that his sexually motivated misconduct, although extremely serious, was out of character. The panel was satisfied that he had full insight into the wrongness of his misconduct and there was little likelihood of repetition. The doctor was suspended for 12 months, which the panel argued would send a message to the public about the seriousness of the misconduct.

Inappropriate behaviour in doctors' personal lives

To sustain and build trust in the profession, doctors need to make sure that their conduct reflects the standards of professional behaviour expected of them,¹²⁰ even when they are not acting in a professional role.

Trust is critical to every aspect of the doctor-patient relationship and there is strong evidence that it is critical in delivering effective medical care. As part of this patients expect their doctor to be an honest and trustworthy individual.

Doctors who break the law, even when the crime does not directly affect their practice as a doctor, will be subject to an investigation. If doctors commit inappropriate acts, it is not relevant whether those affected are aware at the time that the person committing the act was a doctor. In the case study in box 8, the victim did not know the person assaulting them was a doctor, but this serious breach of the law had clearly brought the profession into disrepute.

BOX 8: Case study: inappropriate touching of a stranger

A doctor was referred to the GMC after an alleged sexual assault where he exposed himself to a female passenger sitting next to him on public transport and moved his pelvis against her on three occasions during the journey. He also obstructed her from moving seats and stopped her reporting him to the driver.

The doctor denied that there was any sexual intention and rejected the suggestion that he had acted improperly. He claimed that he had been trying to get comfortable.

The panel thought it was unlikely that the doctor would move in this way accidentally or while asleep three times, and concluded that his behaviour was sexually motivated.

The panel concluded the doctor had not demonstrated any insight, and there was no evidence that he had remediated, so there was a risk of repetition.

Outcome: the doctor was erased from the medical register

The MPTS panel stated this was unacceptable behaviour from anyone, and especially so from a doctor. It was noted that the doctor had not shown insight, and had a high risk of repetition. It concluded that his conduct had brought the profession into disrepute and that such behaviour might cause anxiety to female patients in particular.

Conclusions

Qualitative data gathered by the GMC during the course of its work have obvious limitations and should be seen alongside other evidence. It is possible though to identify issues of concern to doctors and others from this intelligence, and in some cases to discern trends which may require further study.

It is in everyone's interest to understand where professional standards may not be being met and it is important not just that the GMC listens to and acts upon emerging evidence, but that employers, the profession and policymakers develop a better understanding of the areas of risk.

It is equally important that doctors, employers and others consider ways in which they can act to mitigate risk, including whether they need to access or provide more guidance and support.

Chapter four: GMC data and the performance of an organisation

A case study on acute trusts in England

There is a wealth of evidence that demonstrates how poor working environments and ineffective leadership of an organisation can affect professional standards (box 1, page 105). It is also evident that where there are problems with professional and educational standards in an organisation, these not only need to be addressed in their own right, but may also reflect wider systemic issues within the organisation.

Many recent inquiries into failures in the healthcare sector concluded that better sharing of data between regulators of healthcare professionals and regulators of the wider healthcare system may help to identify risks more clearly. Identifying concerns about a healthcare provider may also signal a greater risk to professional standards. That is one reason why the GMC, like others, is striving to share much more data. The extensive online reference tables supplementing this year's report are part of this endeavour.

BOX 1: What aspects of the working environment impact on professional standards?**Findings from research**

The environment affects both how a doctor delivers care and whether they operate to a good standard. One study found that many of the barriers to and enablers of good practice were linked to the environment in which doctors worked.¹²¹ For example, barriers included:

- workload pressures leading to doctors accepting shortcuts that may lower standards
- limited time for reflection
- organisational cultures that discouraged doctors from raising concerns.

Other studies have shown how the care that is delivered can be affected by financial pressures, high levels of clinical demand relative to supply, the quality of managerial and clinical leadership, and the relationship between doctors and managers.¹⁰⁸

Findings from inquiries into failures in the healthcare sector

A succession of inquiries in the past 50 years has shown strikingly consistent patterns of failure¹²² and has highlighted the impact of the working environment on standards.

The most recent inquiries^{31, 32, 123, 124, 125} found a range of common themes across different organisations, such as the culture around raising concerns – doctors felt unable to raise concerns, were not listened to when they did raise concerns, or were given limited feedback after their concerns were raised. Recent inquiries have also highlighted concerns about professional standards that were influenced by or coincidental to problems with the working environment:

- communicating with relatives
- the quality of training
- using antibiotics appropriately
- recording treatments and decisions
- working relationships with the infection control team.

Mitigating the risk of data overload

To avoid being swamped by data, we need to learn as rapidly as possible what data may be particularly useful for different purposes. In the 2013 edition of this report,⁹ we undertook an initial look at the relationship between the data the GMC collects as part of its regulatory operations and systems data. We concluded that there were weak relationships between the two. In this chapter, we examine further whether there is a link between our data and trust-level data by considering acute trusts in England.

Acute trusts in England as a case study

For this analysis, we are drawing on our data related to doctors' fitness to practise medicine in the UK and about doctors' perceptions of training environments. We need a large group of healthcare organisations to examine whether variation in our data (on fitness to practise and doctors' perceptions of training environments) between organisations has a relationship with variation in systems data (such as mortality rates). It is not possible to do this with the smaller number of trusts or boards in the other parts of the UK. However, the findings from 161 acute trusts in England may help towards further thinking in Scotland, Wales and Northern Ireland as well as helping other types of health provider in England.

For example, if there is a higher number of fitness to practise referrals for English NHS trusts that have broad difficulties then it may be that higher fitness to practise referrals for, say, a health board in Scotland could also be one signal of risk for that board. A different analysis might then be merited in Scotland to establish whether there are particular thresholds for the level of doctors' fitness to practise that are a tipping point in the risks for a board, given the particular structure of health systems in Scotland.

The case study on acute NHS trusts in England examines whether indicators of the performance and governance of providers (box 2, page 107) relate to two aspects of the GMC's data.

- The proportion of doctors involved in fitness to practise processes: shown in terms of the proportions who are complained about, are investigated, or receive a sanction or a warning (see figure 25 on pages 60–61 for further details). These proportions are expressed per 1,000 doctors.
- The perceptions of doctors in training: shown in terms of four indicators (with a 0–100 or a 20–100 scoring scale). The four indicators measure doctors' perceptions of the quality of their clinical supervision, their overall satisfaction with their training post, the quality of formal and informal teaching, and how often they received feedback from senior doctors. The data come from the national training survey (NTS) (see page 167 for further details).

BOX 2: Measures of the performance and governance of NHS acute trusts in England

Two measures are used here: Care Quality Commission (CQC) inspection ratings and whether a trust has been put into special measures.

Inspection ratings

The CQC regulates healthcare systems in England, making sure that providers of health and social care – for example hospitals, GP surgeries, care homes and clinics – are fulfilling their obligations to patients and the public through monitoring and inspections.¹²⁶

The CQC introduced inspection ratings in 2014 – providers that are performing poorly are given an ‘inadequate’ or ‘requires improvement’ rating.

Special measures

Monitor and the NHS Trust Development Authority can put foundation trusts and NHS trusts, respectively, into special measures when there are concerns about the quality of care that hospitals are delivering.¹²⁷

This process was introduced in 2013 following a review into the quality of care and treatment provided by 14 acute trusts in England¹²⁸ by Bruce Keogh. The process is designed to offer trusts the support they need to improve, as well as giving the public the ability to hold them to account.

Special measures are designed to deliver improvements quickly, usually within 12 months, through appointing an external improvement director, producing an action plan and partnering the trust with a high-performing NHS foundation trust.

Conclusions from the case study

Despite some limitations to this analysis (box 3, page 109), a number of provisional conclusions can be drawn. Where we refer to 'trusts' in this analysis we are referring to the acute trusts that are included in the analysis.

The proportion of doctors referred to the GMC's fitness to practise processes during 2010–14

- There were proportionately more investigations of doctors in trusts that were defined as poorly performing because they went into special measures in 2013–14 or were given poorer CQC inspection ratings in 2014 – these data are only available for 2013–14 because of when the measures were introduced.
- The proportion of complaints and investigations per doctor were higher in trusts that went into special measures compared with other trusts.
- The higher proportion of investigations of doctors in poorly performing trusts than in better performing ones is driven by referrals from employers and organisations, not by complaints from patients or the public.

The proportion of doctors referred to the GMC's fitness to practice processes in the period before and after a trust is put into special measures

- In the period before trusts were put into special measures, the proportion of doctors who were complained about and investigated increased compared with trusts that were not put into special measures.

- There was a sharper fall in complaints per doctor after special measures were introduced than in trusts not put into special measures over the same time period.
- From a year before a trust entered special measures through to the year after, there was considerable variation between individual trusts in the proportion of doctors referred to and investigated by the GMC. A trust going into special measures is therefore unlikely to be a useful predictor of the proportion of doctors who will become involved in the GMC's fitness to practise processes in an individual trust.

Satisfaction with training

- Doctors' overall satisfaction with their training posts was higher in trusts rated as outstanding than in those rated as inadequate. But there was such a wide range in satisfaction for providers rated in between these extremes that these indicators cannot be used as a predictive measure at the level of the whole trust.
- Doctors' overall satisfaction with their training environment and with clinical supervision declined during the year a trust went into special measures but not thereafter.

The rest of this chapter presents the main evidence for these provisional conclusions.

BOX 3: Limitations to the case study analysis**The complexity and variety of providers**

The indicators of how well a provider is performing or the strength of its governance systems each give different information and have different limitations. Accurately assessing performance is also hindered by the complexity and variety of healthcare settings, even within a category such as NHS acute trusts in England.

The difficulty of using trust-level data

Because of the complexity and variety of providers, aggregating the performance of departments at the provider level is unsatisfactory. This may in part explain the relatively weak associations between trust-level data and the perceptions of doctors in training. Clinical governance and cultures often change from department to department within a large acute trust. We therefore set out at the end of this chapter an example of how data from the national training survey was used to identify and address concerns at departmental level.

The low level of complaints about doctors per trust

The small volume of complaints per trust have meant that, in most of the analysis, we have had to pool the complaints over the five-year period 2010–14. The result of this is that sophisticated analysis of whether there is a difference in the proportion of doctors referred to the GMC between trusts in the period before and after they were put into special measures was not possible. However, we have examined the year-by-year trend throughout this period for the group of trusts that were put in special measures.

Poorly performing trusts have more investigations of their doctors

Trusts with poor CQC inspection ratings

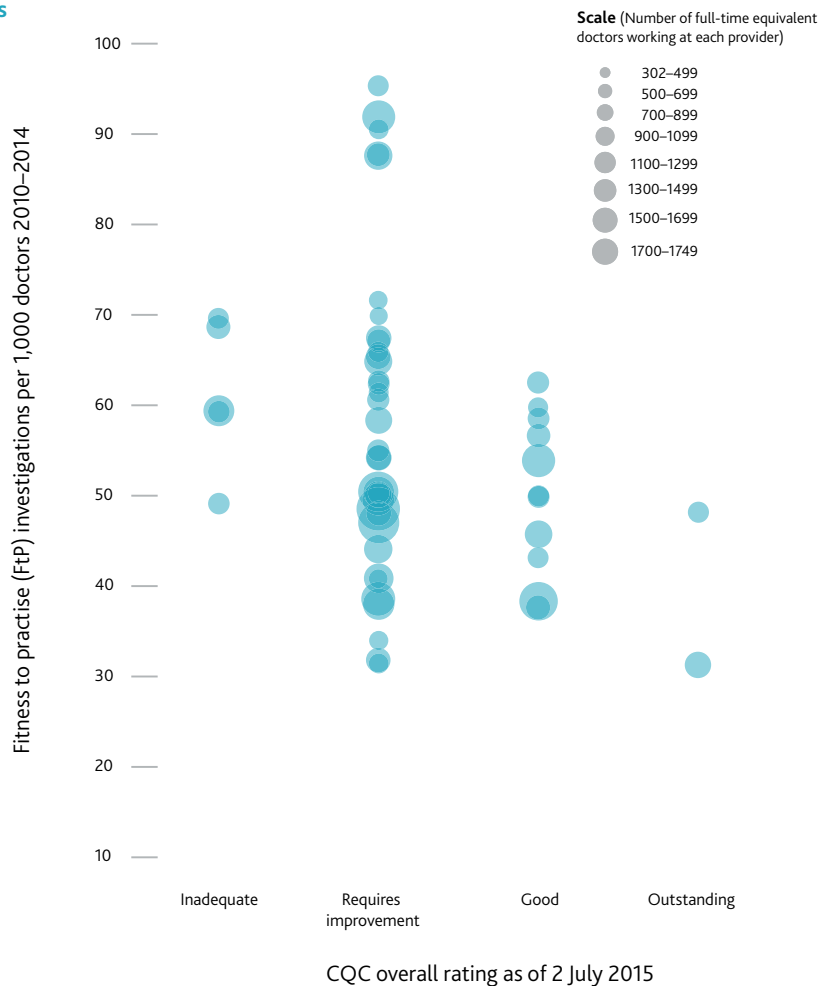
Doctors in trusts with poorer ratings from the CQC were more likely to be investigated by the GMC than those in trusts with higher ratings.

Of the trusts rated good or outstanding, none had a high proportion of doctors being investigated between 2010 and 2014. Of the seven trusts rated inadequate, none had a low proportion of doctors being investigated in this period and two had a high proportion being investigated (figure 41).

Figure 41: Number of investigations about doctors who were working for providers given different CQC ratings, 2010–14*

Providers with a worse CQC rating tend to have more doctors going through a GMC investigation. There are roughly an extra ten investigations per 1,000 full-time doctors – the size of a large acute hospital – for each CQC rating from outstanding through to inadequate.

One provider rated inadequate and one rated outstanding both have around 45 investigations per 1,000 doctors. This highlights the difficulty of trying to differentiate between individual providers based on the number of doctors being investigated.



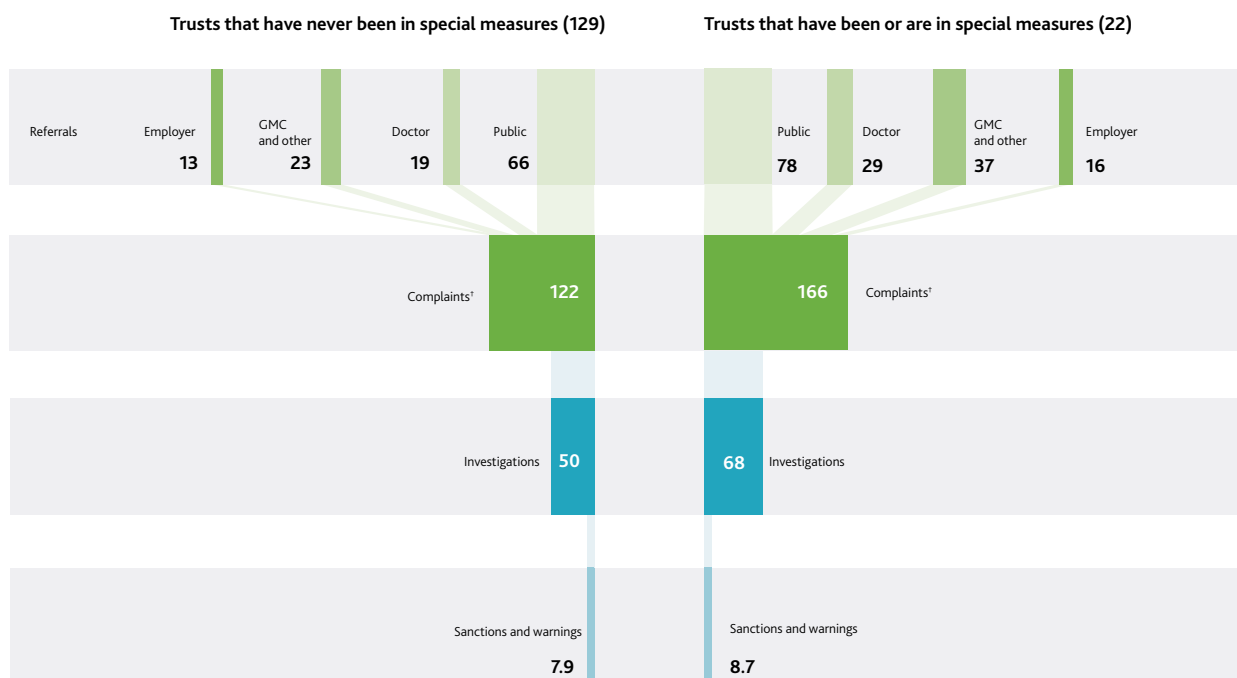
* All acute secondary providers with CQC ratings with over 300 full-time equivalent doctors. The number of doctors is calculated using monthly whole time equivalent figures from the Health & Social Care Information Centre.

Trusts in special measures

14 trusts were put into special measures in 2013, and three more were added in 2014. During the period before and including this (2010–14), these trusts had 36% more complaints per doctor and 37% more investigations than trusts that have never been in special measures (figure 42).

Over the same period, the number of sanctions and warnings per doctor was only 10% higher for trusts in special measures than for other trusts. It is possible that the overall increase in complaints and investigations is a sign that the trust is poorly performing, rather than indicating that doctors are falling below standards to the extent that they require a sanction or a warning to be issued.

Figure 42: Rate* of fitness to practise complaints, investigations and sanctions or warnings 2010-2014, by whether a doctor's employer has entered special measures



* As per 1,000 doctors.

† The number of complaints includes complaints that had not been triaged, ie operational teams were still deciding whether to investigate the complaint. This accounts for minor discrepancies between the number of investigations and referrals and the total number of complaints.

Acute trusts that have been in special measures attracted 36% more complaints for their doctors between 2010 and 2014 than those that did not go into special measures. However, the increase is smaller for the number of sanctions and warnings, 10%.

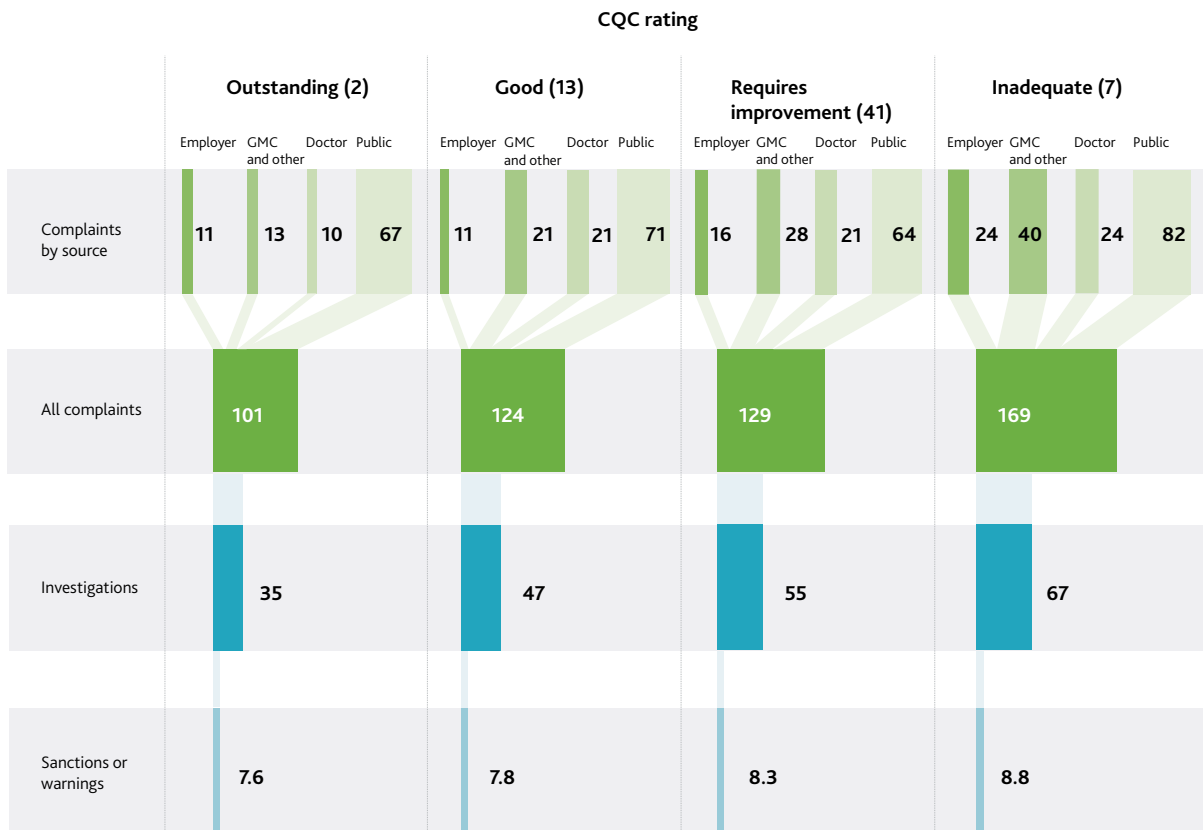
Employer and organisational referrals drive the higher proportion of complaints about doctors*

Between 2010 and 2014, employers and other organisations made double the number of referrals per doctor for trusts rated inadequate by the CQC compared with trusts requiring improvement or rated good or outstanding. Referrals from doctors and patients were also a little higher by 25% and 23% respectively, but these results should be interpreted with caution as few providers have been rated as inadequate or outstanding (figure 43).

Similarly, over the same period, referrals from all sources were more than a third higher in trusts that went into special measures after 2013 than in other trusts, whereas complaints from the public were only 18% higher.

This suggests that concerns were primarily mounting among employers, doctors and other organisations in poorer performing trusts rather than among the public.

Figure 43: Rate† of fitness to practise complaints, investigations and sanctions or warnings in 2010–2014, by the CQC rating of a doctor’s employer



† Fitness to practise events per 1,000 doctors.

* High and low are defined outside one standard deviation from the mean throughout this chapter.

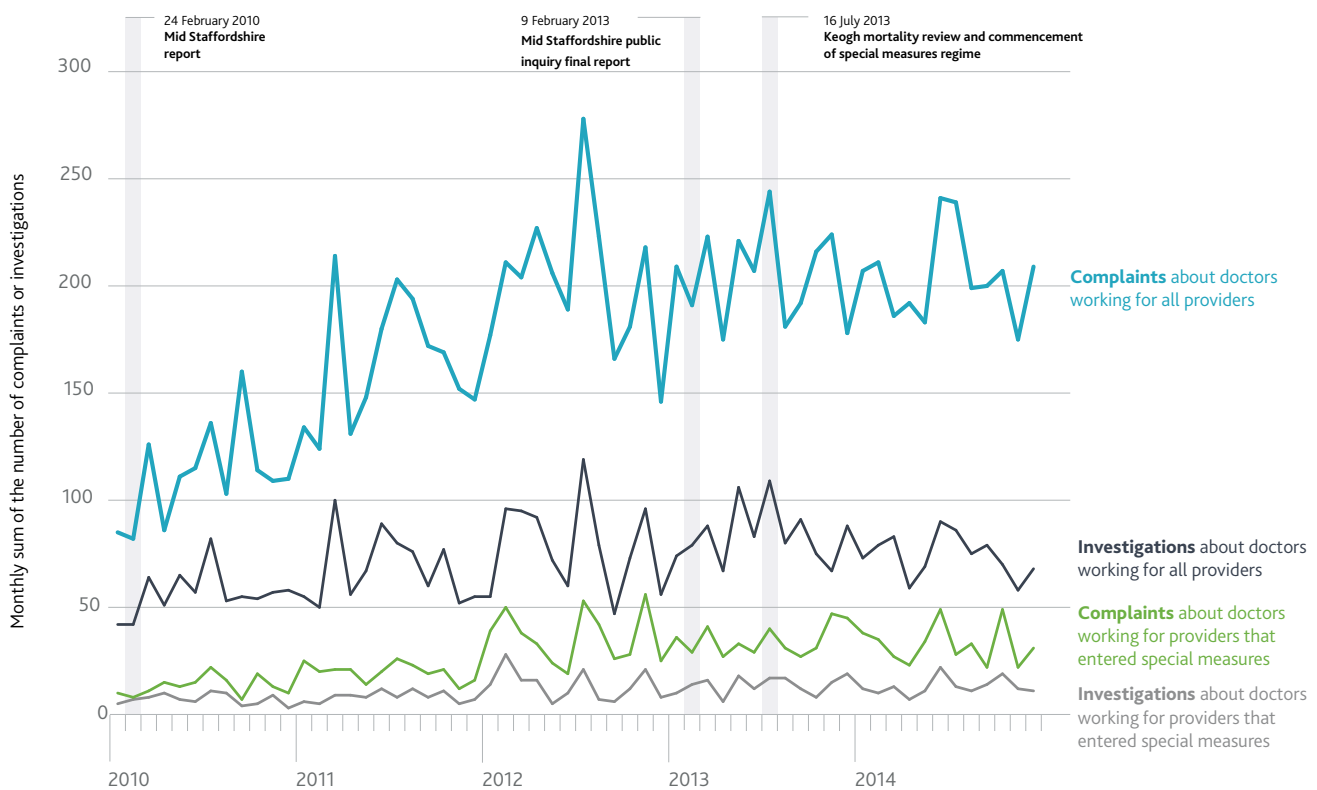
Acute trusts that have been rated inadequate attracted 33% more complaints for their doctors between 2010 and 2014 than those that were rated requires improvement, good or outstanding. The increase is smaller for the number of sanctions and warnings, 7.5%.

The rise in the proportion of doctors referred to the GMC before a trust is put into special measures

The number of complaints to the GMC about doctors working for providers of acute care before the special measures regime was introduced in 2013 (figure 44) rose significantly from 1,337 in 2010 to 2,461 in 2012.

However, these complaints plateaued immediately before the introduction of special measures, where they have stayed. Furthermore, the increase in investigations undertaken by the GMC of doctors working in providers that entered special measures did not increase after the introduction of the special measures regime.

Figure 44: Number of investigations about doctors who were working for all providers and for providers that entered special measures, 2010–14



The number of investigations per doctor may have levelled off once the trust was put into special measures partly because the trust made rapid improvements on some indicators (box 4).

BOX 4: Special measures led to improved outcomes in some trusts

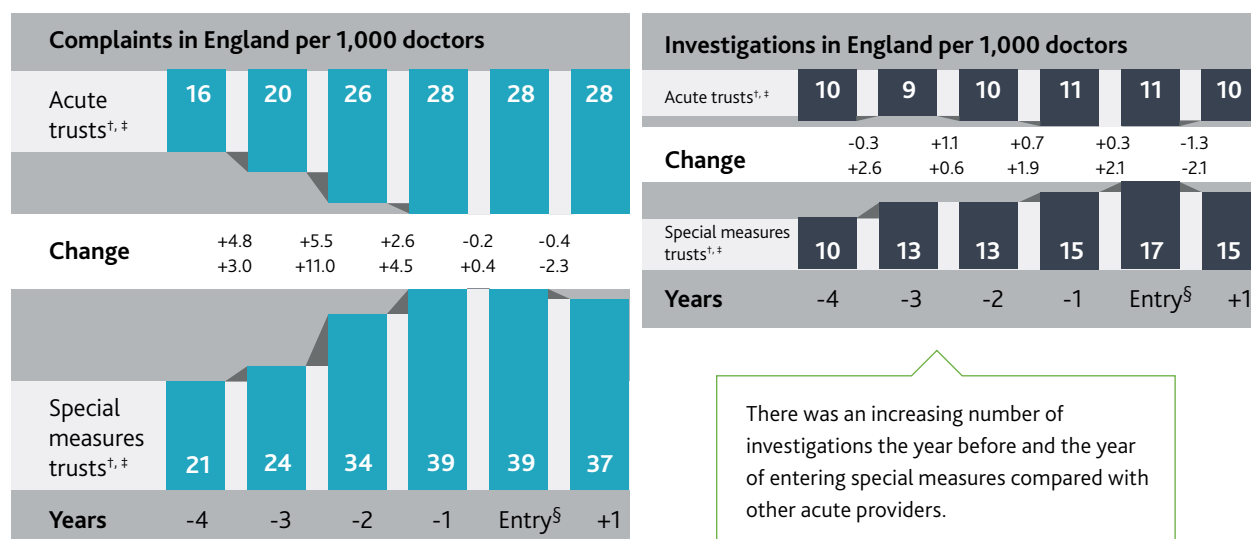
A Dr Foster report¹²⁹ on the 11 trusts that were initially put into special measures found that this process was effective in reducing mortality rates overall. But there was significant variation between the trusts, with the majority of the gains coming from three trusts that substantially improved their mortality data.

George Eliot, East Lancashire, and Basildon trusts went from having an increasing hospital standardised mortality ratio (HSMR) to a decreasing HSMR during special measures. Five trusts showed a consistent improvement, two did not change and one, Tameside, showed a persistent increase in HSMR.

As hoped for, the decrease in HSMR in the 11 trusts overall was significantly faster than in the rest of England, and the variation in HSMR between the 11 trusts reduced beyond what was expected as the trusts with the worst HSMR improved the fastest.¹²⁹

Figure 45 (page 115) shows the annual increase in complaints and investigations in trusts that were put into special measures for the four years before they entered special measures, for the year they entered and for the year after. Although the proportion of complaints and investigations per doctor plateaued just before trusts went into special measures, figure 45 shows that, relative to other trusts, there were higher increases between one and two years before special measures were introduced. The trusts also showed a bigger decline shortly after entering special measures compared with other trusts.

Figure 45: Rate of complaints and investigations about doctors, before and after their provider was put into special measures*



* For this analysis, a weighted average for trusts that have never been in special measures was taken based on the date range used for trusts in special measures.

† Because the 22 providers that entered special measures in the relevant time period did so on different dates, the comparison figure for all acute trusts has been arrived at by weighting different dates.

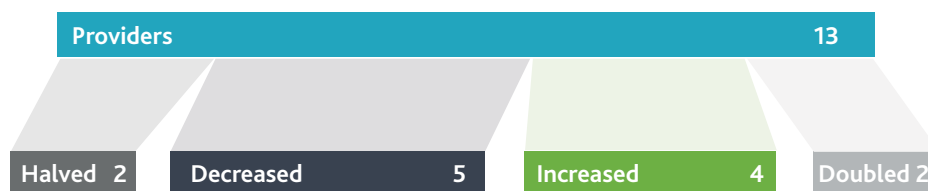
‡ For some providers, there has not been a full year of data, so what data they have have been included with a proportional discount to reflect their limited time in this period.

§ 'Entry' denotes the period 6 months before and after entering special measures. Likewise, the years before or after refer to a 12-month period, so 1 year before, for example, is from 18 months before to 6 months before entering special measures.

It should be noted that across the period from a year before a trust entered special measures to the year after, there was a wide variation between individual trusts in the number of doctors involved in the GMC's fitness to practise processes (figure 46).

This means that a trust going into special measures is not likely to be a good predictor of what proportion of doctors at any individual trust will be involved in fitness to practise issues in future.

Figure 46: The change in fitness to practise investigations for providers* 12 months before and after special measures



* Only 13 providers with at least 11 months of data following special measures were included.

Doctors' perceptions of training environments

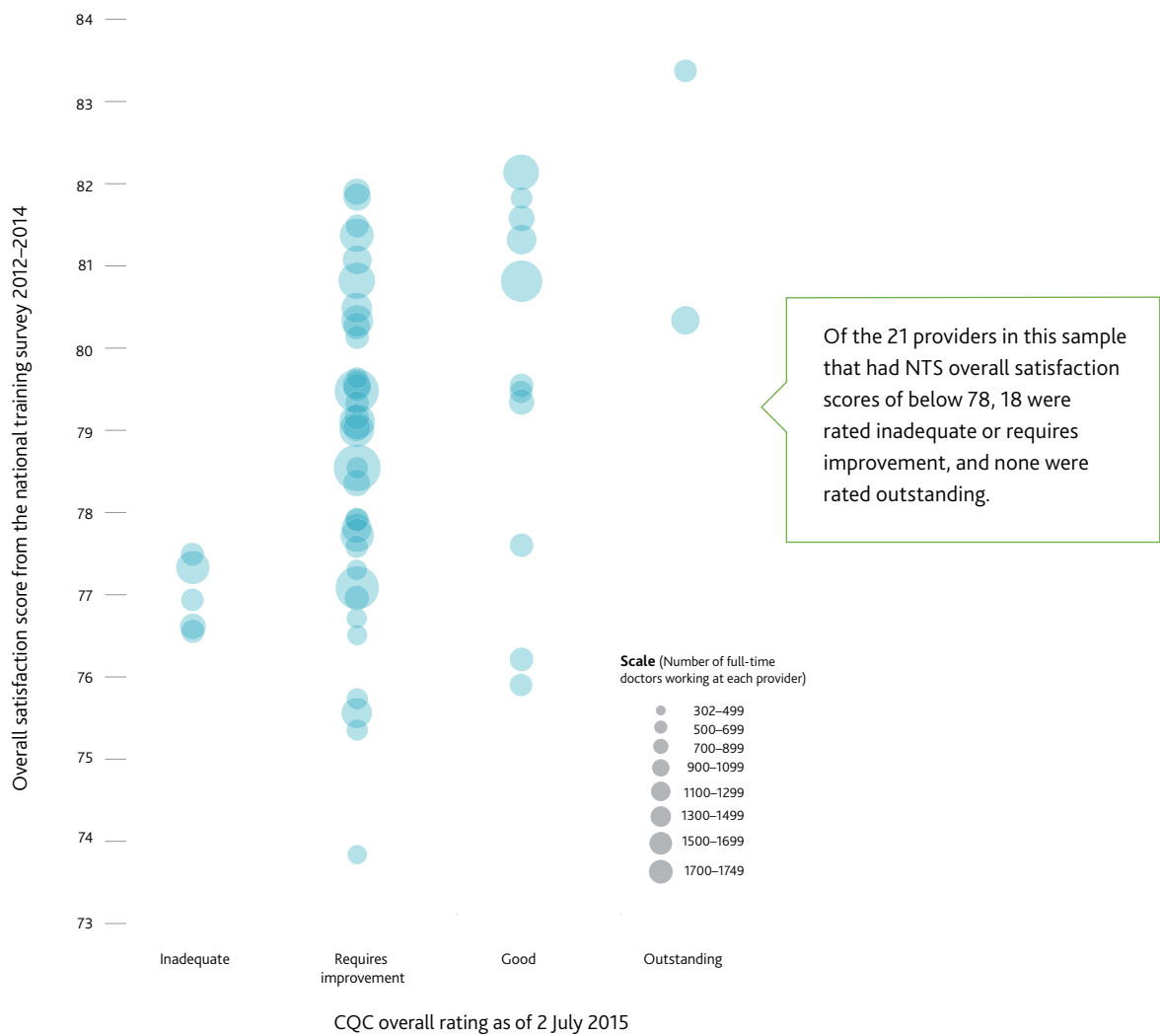
Doctors' overall satisfaction with the training environment is associated with CQC ratings, but there is a wide range of scores within each rating category

On average, doctors in training reported higher overall satisfaction with training posts in providers rated outstanding than in those rated inadequate, and gave a wide range of overall satisfaction scores for providers rated as requiring improvement or as good (figure 46, page 118). The fact that overall satisfaction improves with the providers' performance confirms to some extent GMC teams' experiences on visits to providers, which have shown poor training often coincides with challenges in giving patients a safe service. But there is a wide range of overall satisfaction scores for each CQC rating, which precludes the use of these indicators from the national training survey as a predictive measure.

Even where a provider is rated good, doctors in training can be much less satisfied than in providers rated as inadequate, and a good CQC rating does not guarantee that doctors in training will be satisfied. This may reflect differences in providers' commitment to doctors' learning. That is one reason why it is necessary to assess educational performance in all providers, and not just these with poor performance on systems measures. A similar pattern is found for the clinical supervision indicator.

The wide range of results reflects the different dimensions of performance measured by the national training survey and by CQC inspections. The former is focused on issues with department-level training close to the frontline of clinical work, whereas the latter looks at a broad range of factors at different levels across a provider, including board governance, wider support and safeguarding systems, patient experience and other staff groups such as nurses.

Figure 47: Overall satisfaction of doctors in training 2012–14 who were working for providers given different CQC ratings*



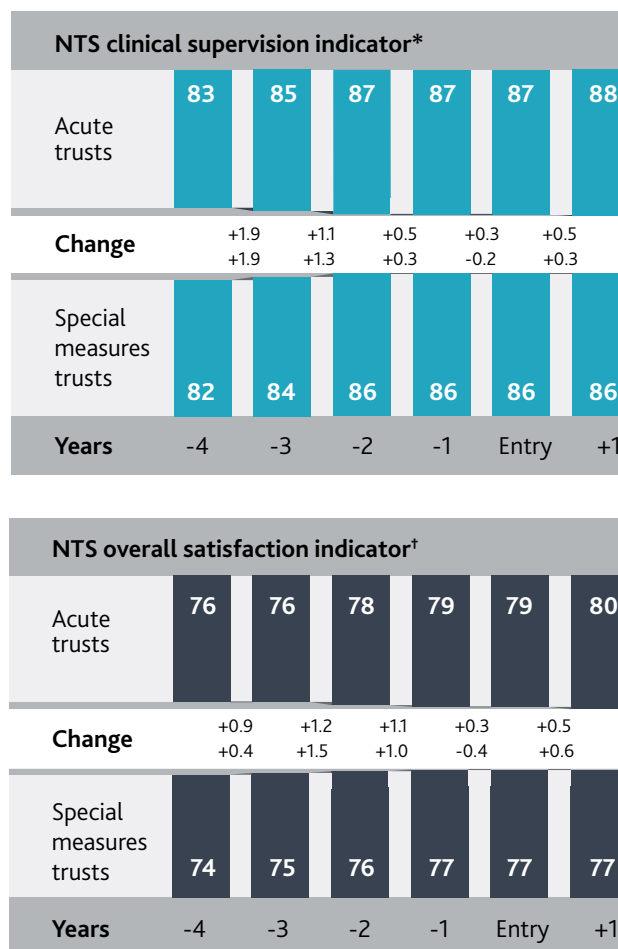
* All acute secondary providers with CQC ratings with over 300 full-time equivalent doctors. The overall satisfaction indicator is averaged for years 2012–2014.

Doctors' overall satisfaction and perception of clinical supervision declined in the year a trust went into special measures, but not afterwards

There is a decline in doctors' overall satisfaction and perceptions of clinical supervision in the year a trust goes into special measures but, once a trust is in special measures, trends in these indicators do not differ greatly from other trusts (figure 48).

Both overall satisfaction and clinical supervision plateau for the year during and after providers enter special measures, compared with those not in special measures for the same period.

Figure 48: Doctors' overall satisfaction with their training and perceptions of clinical supervision, before and after their provider was put into special measures



* The NTS clinical supervision indicator is an aggregate score of responses to five questions:

- In this post did you always know who was providing your clinical supervision when you were working?
- In this post how often, if ever, were you clinically supervised by someone who you felt wasn't competent to do so?
- In this post how often did you feel forced to cope with clinical problems beyond your competence or experience?
- In this post how often have you been expected to obtain consent for procedures where you feel you do not understand the proposed interventions and its risks?
- How would you rate the quality of clinical supervision in this post?

† The NTS overall satisfaction indicator is an aggregate score of responses to five questions:

- How would you rate the quality of teaching (informal and bedside teaching as well as formal and organised sessions) in this post?
- How would you rate the quality of clinical supervision in this post?
- How would you rate the quality of experience in this post?
- How would you describe this post to a friend who was thinking of applying for it?
- How useful do you feel this post will be for your future career?

The use of national training survey data for specific departments within a trust

The national training survey is designed to measure doctors' perceptions of training posts and programmes, rather than to make a global assessment of the training provided by a healthcare organisation. It is perhaps not surprising then that it does not predict broad performance issues at the level of the provider.

The national training survey has been running since 2006, and since 2009 the survey indicators have been used to identify problems with training and patient safety in specific departments, where groups of doctors share a training post specialty at a given site (box 5, page 121). When a specialty at a site has been a 'below outlier'* on a particular indicator, the deanery or local education and training board (LETB) and the GMC monitoring teams are asked to investigate. In 2014, there were 148 'below outlier' indicators for three consecutive years across 73 providers (across 90 sites) in the UK. In 2015, there were 182 'below outlier' indicators for three consecutive years, and 67 for four consecutive years.

Survey results typically vary across departments within the same provider. This is the level at which most action can be taken to address the governance and training issues that most affect clinicians and healthcare teams' performance, such as how supportive line managers are, or what clinical governance systems are in place.

New questions in the survey ask doctors about how supportive they consider their training environment. These should give traction to questions of how a department is run and what it is like for the staff that work there.

We could not test the relationship between these new survey questions and providers' CQC ratings. This will be an important avenue for future analysis.

* The score for the indicator is significantly below the national score in the benchmark group. A score is defined as being a below outlier if it meets all of the following criteria.

- The upper 95% confidence limit associated with the indicator score must be below the lower 95% confidence limit of the benchmark indicator mean score.
- The mean of the indicator score must be below the lower quartile (Q1) score of the benchmark group.

BOX 5: Case study: using the national training survey to identify problems in the Trauma and Orthopaedics Unit at Southampton General Hospital

In 2013, Wessex Deanery asked the GMC to place the Trauma and Orthopaedics Unit at Southampton General Hospital under the enhanced monitoring process. This followed evidence from the national training survey that eight of 12 indicators were 'below outliers'. A joint inspection visit by the GMC and the Deanery in November 2013 identified a number of issues: foundation doctors reported difficulties securing support from more senior doctors, and doctors in specialty training reported concerns about clinical supervision in theatres and clinics. They also reported that they were not being exposed to adequate experience in key areas.

The visiting team recommended a detailed review of how the service was organised, and especially the precedence of service over training needs. The concerns escalated to the point where the GMC considered removing doctors in training. However, with new managerial and clinical leadership, and commitment to address the issues from the board of University Hospital Southampton NHS Foundation Trust, dramatic improvements were made to the department.

The position was transformed. An action plan was agreed and the Trauma and Orthopaedics Unit has now made training a priority. Focused individual training programmes are now offered and for the first time doctors in training are asking to be placed at this unit. Wessex Deanery reported that patient outcomes have improved. The 2015 national training survey indicators showed a dramatic improvement on the previous year, with no 'below outliers' and an 'above outlier' for handover.

Figure 49: Outliers in the national training survey for the Trauma and Orthopaedics Unit at Southampton General Hospital in 2013–15

NTS indicators

- Below outlier
- Low
- Above outlier
- No data
- Not an outlier

Indicator	Outcome		
	2013	2014	2015
Overall satisfaction	61	59	87
Clinical supervision	71	75	89
Clinical supervision out of hours			89
Handover	75	88	98
Induction	63	59	98
Adequate experience	64	62	85
Supportive environment			76
Work load	24	20	37
Educational supervision	84	83	91
Access to educational resources	53	48	71
Feedback	49	62	78
Local teaching	40	53	64
Regional teaching	63	76	71
Study leave	50	52	74

Chapter five:

Understanding differences in educational attainment

It is now accepted that there are significant differences in the attainment of different groups of medical students and that these differences are also reflected in the progress doctors make in some specialty training programmes and in GP training.¹³⁰ Many of the differences in attainment are found across higher education more widely, and are not just limited to medical education.

A literature review of differential attainment in medical education,¹³¹ commissioned by the GMC, together with an in-depth analysis of the GP exam, has provided further evidence and background to this important topic. In addition, the medical royal colleges have provided a raft of data on exams, progression and recruitment, and in this chapter we provide the early findings from an analysis of this evidence and other work in this area.

Doctors should expect appropriate academic and personal support, including when they are not progressing well.^{54, 132} Those who regulate, provide and manage training must better understand how to support doctors in training, including what their learning needs are, and make sure they are treated fairly. Making sure that the standards, and the training pathways that deliver them, are fair, valid and justifiable, and discriminate only on the basis of appropriate professional competence is clearly important; as is making sure that the training pathway is flexible enough to accommodate doctors from different social and cultural backgrounds.

Understanding differences in outcomes for doctors in training

Levels of attainment vary as a result of individual effort and ability. However, persistent variations between the average attainment of one group and that of another may indicate that other factors are at play.

This could happen for a number of reasons. For example, the assessments of performance themselves could be unfair to particular differences in ability. Or a particular group may be more prone to a factor that influences attainment, such as not having English as a first language. It may also be that the broader social context of being a member of a particular group makes, for example, accessing student support harder.

There is evidence that the differences in attainment are not explained by bias from assessors, though the precise reasons for variation in educational attainment are still unclear.

There are many organisations working to understand and address these differences in outcomes.* Understanding what is behind these persistent gaps will help make sure that both assessment methods and support arrangements are appropriate – ie that they allow all individuals, irrespective of their characteristics, to realise their potential.

* Organisations such as the British Association of Physicians of Indian Origin, the British Medical Association, the medical royal colleges, deaneries and local education and training boards, and the Medical Schools Council.

The focus of this chapter

To cover these issues, this chapter is divided into three broad sections.

- **What is the nature of observed differences in attainment?**
We have looked overall and at each stage of training, controlling for differences in attainment at the previous stage.
- **What are the potential reasons for these observed differences?**
We have looked at bias in exams, differences in language proficiency and communication skills, other cultural factors, and doctors' experiences of the training environment.
- **What are deaneries and LETBs already doing to support doctors?**
We report on a recent survey by the GMC.

The data available are improving, but are still partial and some analysis is therefore necessarily limited.

We focus on the differences between doctors of different ethnicities and between UK graduates,* European Economic Area (EEA) graduates[†] and international medical graduates (IMGs).[‡] Other differences in attainment exist, such as differences based on gender or age, but we are focusing on ethnicity and place of primary medical qualification as these have been better studied. In terms of ethnicity we are largely reporting on two very broad groups – doctors who are white and doctors who are black and minority ethnic (BME) – because of data availability and sample sizes. The data usefully identify some differences between these broad groups, but mask a great deal of variation within them, which we hope may be the subject of further investigation in the future.

* UK graduates are doctors who gained their primary medical qualification in a UK medical school.

† EEA graduates are doctors who gained their primary medical qualification in the EEA, but outside the UK, and who are EEA nationals or have European Community rights to be treated as EEA nationals.

‡ IMGs are doctors who gained their primary medical qualification outside the UK, EEA and Switzerland, and who do not have European Community rights to work in the UK.

What is the nature of the observed differences in attainment?

There is an established and accepted gap in attainment between white and BME learners at different stages of education and it is now also clear that ethnicity is a factor in doctors' attainment from secondary school onwards. This has been demonstrated in research on GP, medicine, obstetrics and gynaecology and psychiatry exams.⁵⁷

In this section, we summarise the overall differences in attainment from recruitment and exam data, before looking at the differences at each stage of education and training that might possibly explain some of these overall differences.

Overall differences

Research on exam performance at the end of GP training has shown that BME doctors and non-UK graduates are more likely to fail than others (box 1, page 126). This year the GMC collected and analysed data across all specialties. The data show the lower attainment of BME doctors and non-UK graduates is fairly consistent across all specialties.

- BME UK graduates were more likely (72%) than white EEAs (53%) or IMGs (49%) to get an offer of a post in the first specialty (core) recruitment round, and to pass their exams.
- UK graduates passed their postgraduate exams* over 70% of the time, whereas EEA graduates and IMGs passed less than 50% of the time.
- BME UK graduates were less likely to get an offer of a post in the first recruitment round for those in foundation training applying to Level 1 (L1) training than white UK graduates (72% vs 81%) and less likely to pass their exams once in training (64% vs 76%).

* This includes all attempts, not only the first attempt to pass postgraduate medical exams. Exams data currently only cover one year.

BOX 1: Differential attainment in the final GP exam

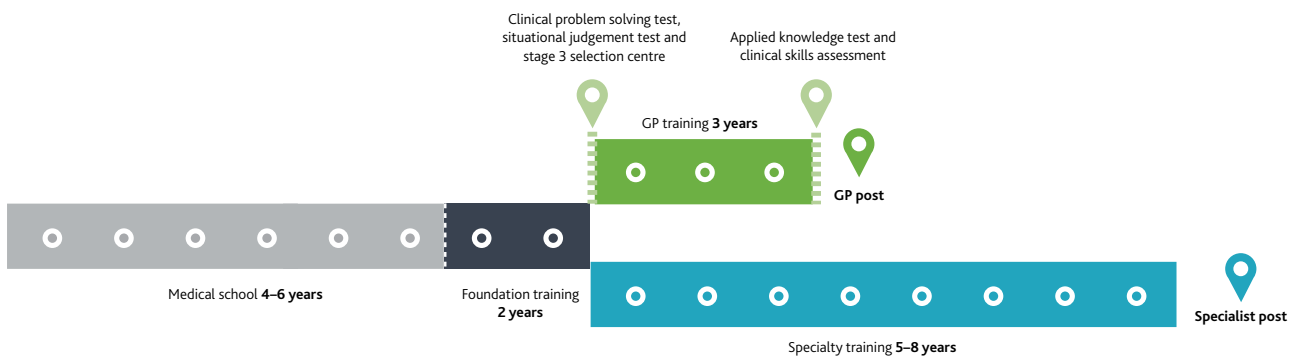
Research¹³³ examined differential attainment in the Membership of the Royal College of General Practitioners (MRCGP) exam, which is the final exam that doctors take to become a GP and is made up of a workplace-based assessment and two tests.

- Applied knowledge test – a computer-marked test of 200 questions that assesses the knowledge that underpins general practice.
- Clinical skills assessment – a simulation of a GP surgery using actors to portray patients. This tests a doctor’s ability to gather information and apply learned understanding of disease processes and person-centred care.

The study found BME UK graduates were nearly four times more likely to fail the clinical skills assessment examination at their first attempt than their white UK colleagues, although the difference disappeared at the second attempt – this chapter goes on to explain that this difference is only partially explained by the previous academic attainment of the doctors. BME IMGs are nearly 15 times more likely to fail this exam than their white UK colleagues, and the difference between the two groups persists at subsequent sittings.

The researchers found that these differences were not due to the way they were assessed in the clinical skills assessment and raised the question of whether the differences might be explained in part by lower test scores on entry to the GP training programme. The report also noted the issue of cultural context in the exams and the potential for bias. We consider these issues in this chapter.

Figure 50: The stages of medical education and GP training assessments



Differences at each stage of education

When looking at doctors' training, it is important to understand where the gap between groups has grown or shrunk from the beginning to the end of the programme. These changes can identify where those with low scores on entry have been supported to develop in a way that kept pace with or advanced on those who scored highly in the selection test.

Education at both secondary and medical schools

On average BME medical students enter medical school with slightly lower A-level results than white students.¹³⁴ However, separate analysis of undergraduate and postgraduate exam performance has found a stronger difference between BME and white students. This suggests that the gap in performance cannot solely be explained by differences in attainment on entry.

A number of studies have shown that UK medical students from ethnic minorities significantly underperform in assessments compared with their white counterparts.¹³⁰ This is not a phenomenon limited to medical schools. Overall in England, for example, white students tend to get higher grades than BME students even if they have the same A-level results – in other words, the differential attainment gap continues to grow at the university stage of education. Of students entering with three grade Bs at A-level, nearly three-quarters of white students (72%) achieved a first or upper second degree whereas only just over half of their Asian and black counterparts did so (56% and 53% respectively).

It is good that medical schools actively seek to widen access but the tendency for the attainment gap between white and BME students to widen on average during this stage of education is a cause for concern. The reasons are not fully understood but there may be a case for providing additional support to address this.

Postgraduate training

Following the research that identified the large gap in attainment in the final GP exam (box 1, page 126), the GMC commissioned work to examine how much of the variation between individuals in these final exams was a result of differences in ability at the outset of GP training.¹³⁵

Those applying to do GP training take a three-stage assessment in the form of:

- longlisting
- selection tests (the clinical problem solving test and the situational judgement test),
- a selection centre assessment.

The research found that the selection tests, together with the selection centre assessment, were good predictors of performance in the final exams and together can explain 56% of the variance in applied knowledge test scores and 41% of the variance in clinical skills assessment scores.*

The success rate of doctors who achieved a borderline score on entry to GP training in passing both the clinical skills assessment and applied knowledge test was only 46%. By contrast, close to 90% of doctors in training who achieved a clear pass at selection also passed the applied knowledge test and clinical skills assessment.

* Not controlling for age and sex.

IMGs applying to GP training programmes in the UK are required to achieve a minimum overall standard in the International English Language Testing System (IELTS) test. They may also be asked to demonstrate their clinical knowledge in the Professional and Linguistic Assessments Board (PLAB) test (box 2, page 129). Differences in these scores also account for part of the variation in the MRCPG results: the PLAB test explains an additional 3–4% of variance in the MRCPG exam and the IELTS scores can explain a further 2–3% of variance, in addition to all the other test data.*

Overall, therefore, as figure 51 (page 129) illustrates, around 40% of the variation in clinical skills assessment results and about 60% of the variation in applied knowledge test results appear to be caused by factors other than differences in previous attainment, as measured by the selection centre assessments and PLAB results. Among these will be, for example, the differences stemming from the different effort and skills that individuals exhibit during GP training. However, the research also looked at the amount of the variation that seems to be associated with ethnicity and place of primary medical qualification. It found that after controlling for the effect of different ability at entry to the training, ethnicity and place of primary medical qualification are associated with 1.3% of the variation in individual scores in the applied knowledge test and 9.1% for the clinical skills assessment.*

Research has also shown some differences in attainment between other demographic characteristics, such as age and gender.† Minority ethnic groups and those who gained their primary medical qualification in different places have different average ages and gender mixes so the differences between those groups' performance v others will also be affected by those factors.

When we control for both previous attainment at entry to training‡ and the age and gender differences:

- 1.1% of variation in the applied knowledge test is associated with ethnicity and place of primary medical qualification
- 5.3% of variation in the clinical skills assessment is associated with ethnicity and place of primary medical qualification.§

Low scores on entry to the GP training programme are a predictor of success in the AKT and CSA components of the final exam. Early discussions between doctors in training and their supervisors about support may help increase the likelihood of passing. Scores on entry do not entirely explain the difference, however; there remains a small amount of unexplained difference related to primary medical qualification and ethnicity. We examine other potential causes below.

* Not controlling for age and sex.

† For example, in the GMC in-house analysis published in March 2015, we found that female doctors were more likely to pass their exams or to be offered a training post.

‡ Not including PLAB results.

§ Any statistical analysis of this type requires caution: the issue is complex and difficult to disentangle.

Figure 51: Amount of variation in MRCGP results that is explained by results in the selection tests, selection centre assessments and PLAB test

Type of final GP exam	Variation explained by:		
	(a) entry assessment results*	(b) selection centre assessment results, after controlling for (a)	(c) Professional and Linguistic Assessments Board (PLAB) results [†] after controlling for (a) and (b)
Applied knowledge test	55.3%	0.4%	3.8%
Clinical skills assessment	36.7%	4.3%	3.4%

* Entry assessment tests are the clinical problem solving test (CPST) and the situational judgement test (SJT) and are required to secure a position as a doctor in GP training.

† For those non-UK doctors that had to take these assessments in order to register for UK practice.

BOX 2: Assessing doctors' clinical knowledge with the PLAB test

IMGs take the two-part PLAB test when they are applying to practise in the UK.

The PLAB test is set at the standard of a UK graduate on the first day of their second year of foundation training (F2). It is designed, therefore, to align with the standard expected of a doctor who is fully registered.[‡] It is not designed to select candidates who have the potential for postgraduate training, nor can such a test make sure that IMGs' abilities are the same as those of UK graduates.

Research found that the pass marks of the first and second parts of the PLAB test would have to be raised by 13% and 20% respectively to make sure UK graduates and IMGs achieve equal attainment in the MRCGP and Membership of the Royal Colleges of Physicians of the United Kingdom (MRCP(UK)) exams.¹³⁶

Further research examined the different progression outcomes of UK and non-UK graduates.¹³⁷ It found that a smaller proportion of non-UK graduates achieved satisfactory outcomes in the annual review of competence progression (ARCP) during postgraduate training, even after adjusting for the potential confounders of age, gender, years of UK-based practice, ethnicity and postgraduate exam failure. The research also found that the difference would disappear after raising the pass mark of the first part of the PLAB test by 32 points, restricting it to only the highest scoring 8% of candidates. Restricting entry to only the highest performing applicants would fail to consider fully the often short-term cultural and social learning needs of some non-UK graduates. It was also noted in the research that restricting the intake of non-UK graduates would have serious consequences for workforce planning.

‡ Full registration is awarded to doctors from UK medical schools when they complete the first year of foundation training (F1).

What are the potential reasons for the observed differences in attainment?

Strong evidence on why the average attainment differs between various groups of medical students and doctors in training is still relatively sparse, despite the considerable concern and research efforts. An understanding of the range of potential causes is essential in considering what interventions might be effective in ensuring all medical students and doctors in training reach their potential.

Possible bias in exams and the issue of cultural context in assessment

It is possible that the design or implementation of assessments may disadvantage some groups and that differences in performance are partly accounted for by this rather than by any difference in ability or effort. Bias* is a challenging research topic for a number of reasons and is extremely difficult to detect directly, particularly in statistical terms.

However, one approach is to compare multiple-choice written tests marked by computers with practical clinical assessments marked by assessors. In a meta-analysis¹³⁰ of undergraduate and postgraduate assessments, researchers concluded that, in the sample considered, bias from assessors could not explain the differences in attainment between white and BME doctors because a similar difference was found in the exams marked by computers.

* Bias can be defined as an inclination or prejudice for or against one person or group, especially in a way that might be considered to be unfair. Unconscious bias is where behaviour or attitudes towards other people are more likely to be influenced by instinctive feelings than by any complex thinking about the facts at hand (or a purely rational decision).

Another study analysed the scores that examiners gave 52,000 doctors taking the clinical skills assessment in the MRCGP exam in 2011–12.¹³⁸ They found that, while some examiners tend to give higher or lower marks across all candidates, there is no evidence of bias by gender, and only one of 29 assessors showed evidence of bias by ethnicity.¹³⁹ The Royal College of Physicians is aiming to raise awareness of differential attainment among its examiners and is setting up an exam-specific equality and diversity training programme. It is also looking into training lay people to assess candidates in exams alongside doctors.

There may be aspects of certain assessments that impact differently on groups coming from different social or cultural positions. For example, qualitative work by King's College London¹⁴⁰ suggests that exams and assessments might sometimes focus on capabilities that are often not part of the curriculum, such as use of body language, which come more easily to those trained in the UK than to those trained in some other places.

However, medical practice is not culturally neutral. Working within a culture to build effective relationships with patients is key to helping them improve their health. So assessments do and should have a cultural element, although it's not known to what extent assessments accurately reflect the diverse cultural norms across the UK. Some medical students and doctors in training will need more support to develop skills in this area than others where the doctors' patients may be particularly culturally different. We return to some cultural issues that may impact on differential attainment below.

Differences in language proficiency and cultural context

A large proportion of non-UK graduates who are training in the UK are from countries where the first language is not English. In their first years of UK practice, these doctors can, understandably, be less fluent in written and spoken English, and lack awareness of the cultural expectations in the NHS and of doctor-patient relationships in the UK. This is an issue that is changeable through acculturation – adopting or adjusting to the relevant beliefs and behaviours of another group of people. But it may well take time for doctors in training to learn and understand the cultural norms within which they practise.

Language proficiency alone explained only a small part of the differences in performance. In research on the MRCGP exam, after controlling for the GP selection assessments, higher scores on the IELTS test were only weakly associated with better results. Differences in IELTS scores accounted for 2.3% and 3% respectively of the variation in individuals' applied knowledge test and clinical skills assessment results.¹³¹

However, language, in terms of ability to communicate effectively in a UK setting, was also deemed to be important in the MRCGP clinical skills assessment by more qualitative research.¹⁴⁰ Where some non-UK graduates lacked fluency, they could come across as formulaic and focused on their own thinking rather than on the needs of the patients.¹⁴⁰

Effective communication is important for building working relationships with patients. Interestingly, there are more EEA graduates and IMGs in general practice. GPs often have to rely heavily on a nuanced understanding of country-specific social norms to build such partnerships for care and recovery.

Other cultural factors

Research on how cultural factors may impact on differential attainment is very patchy. The recent literature review¹³¹ that the GMC commissioned suggested a number of avenues for further exploration. Here we present the conclusions from the review of mainly small scale research between 2004 and 2014. In view of the small-scale of many of these studies, they are used as pointers to where further investigation may be useful.

Social capital

Social capital – the value of the networks that an individual enjoys – has been shown to have an impact on progression and attainment in many different areas of life, including medicine.

One study surveyed 158 medical students about their social networks.¹⁴¹ Students who shared religion or ethnicity tended to form their own distinct social networks, but there was no link between these and academic achievement. There was, however, a link between students achieving and being able to name at least one tutor or clinician in their network. They concluded that social capital may be an important factor in explaining differential attainment between ethnic groups.

A very small study of 19 high-achieving medical students in Saudi Arabia identified that they were motivated by family support as well as having personal attributes such as a learning strategy, ability to manage their own resources, and the capacity to manage non-academic problems.¹⁴² The effect of social networks has also been observed in the UK. A study of medical students in their second year at University College London found that the formation of friendships affected subsequent exam success.¹⁴³ The results of this study also suggested that, while medical students chose friends of the same sex and ethnic group as themselves, the allocation of students to tutor groups also influenced friendships.

Learning styles and personalities

Using a psychological survey tool (NEO PI-R), researchers found differences in learning styles, parental factors and personalities between white and BME medical students.⁵⁵

BME and white students did not differ significantly on the personality traits of neuroticism, agreeableness and conscientiousness, but BME students were more likely on average to score lower on the 'open to experience' domain. This domain looked at their attentiveness to inner feelings, aesthetic sensitivity, fantasy imagination, preference for variety and curiosity.

However, ethnicity had a predictive effect on final exam performance, even after including these factors in the model, indicating that the differences in performance were not due to differences in openness to experience or other recorded factors in the survey such as prior education, first language or age.

The influence of stereotyping

A small (25 medical students and 27 teachers) qualitative study¹⁴⁴ at a London medical school suggested that stereotyping medical students affected teaching and learning. Both students and teachers had defined ideas of what a good student and a good teacher looked like. Both groups also had a relatively well-defined picture of what a typical Asian medical student was like – this did not match their picture of a good student and assumed, among other things, that they had been pushed into studying medicine by ambitious parents. If such negative stereotyping does exist, it may lead to underperformance of the groups where teachers treat them differently.

Experience of the training environment

It is clear that future research needs to address the entire educational journey rather than just its end point, as represented by indicators such as exam results. There is also a need to pay more attention to the impact of the wider environment and how it facilitates or hinders progress among different groups of doctors in training. The GMC has commissioned some qualitative research to understand this area better.

The GMC’s national training survey contains some information on how the training environment is experienced. At a national level, across all specialties, there is no substantive difference between the average scores given by BME doctors and the average scores given by white doctors (figure 52). The small group of respondents who prefer not to say what their ethnicity is tend to have lower scores than either, but the differences are extremely small.

Figure 52: National differences between ethnic groups in their perceptions of the provision of training and their working environment*



* National training survey questions cover in particular the clinical and educational support that doctors in training experience. Responses are split into different subjects referred to as indicators, for example clinical supervision or handover. These indicators are given a score out of 100 for each training environment. Any differences in responses between different groups of doctor could be illustrative of differing experiences of the training environment.

The responses to the bullying and undermining questions, however, do reveal differences in the experience of different cohorts, with higher percentages of overseas graduates witnessing or experiencing bullying or undermining at some point in their training post (figure 53). BME doctors who graduated from a UK medical school were more likely to report bullying or undermining than white UK graduates. However, a slightly higher proportion of white IMGs and EEA graduates reported bullying or undermining than their BME counterparts.

The specialty and the stage they are at, as well as their training environment, can all affect the likelihood that doctors will report bullying and undermining.¹⁰²

Figure 53: National differences between ethnic groups by their place of primary medical qualification on whether they report witnessing or experiencing bullying or undermining

	EEA		IMG		UK	
	White	BME	White	BME	White	BME
Witnessed or experienced bullying or undermining	13%	11%	14%	12%	9%	11%
Never witnessed or experienced bullying or undermining	81%	82%	79%	78%	89%	84%
Prefer not to answer	6%	7%	8%	10%	3%	5%

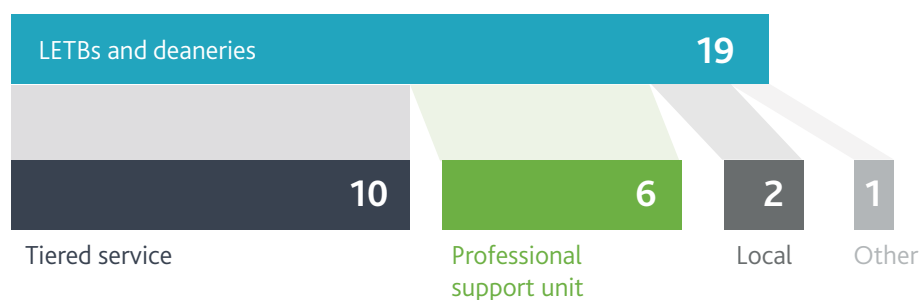
What are deaneries and LETBs doing to support doctors?

Every deanery and local education and training board (LETB) provides support in some form to their doctors in training. The GMC conducted a survey in 2015 interviewing individuals from 19 LETBs and deaneries across the UK – including postgraduate deans, Responsible Officers and associate deans – to find out about the types of support they provide.

Types of support services

The survey identified that support is delivered in many different ways, both informally in the day-to-day business of teaching and learning, as well as more formally, through dedicated professional support units. A range of different strategies are used (figure 54). Most deaneries and LETBs provide a tiered system of local support and central services, but some provide most support through a central support team, and others provide support locally via clinical and educational supervisors and employers.

Figure 54: How professional support is delivered across 19 LETBs and deaneries



Strategies also differ, with some deaneries allowing doctors to self-refer to central support teams and with others providing targeted support. There are many examples of good practice¹⁴⁵ in the area of educational support (box 3).

There are many decisions that LETBs and deaneries can make about how to select doctors in training for support, what the support involves, and how to deliver the support. The support available differs depending on the deanery or LETB, with some seeking to prevent problems by identifying doctors' needs at an early stage, some tailoring their programmes around the needs of the individual doctor in training, and some explicitly separating support from performance management.

Although there has been some research in this area, there is little investment in evaluating the effectiveness of these services or support strategies.

As respondents to the survey suggested, better coordinated data collection and the development of longitudinal datasets would be helpful in establishing which support arrangements are most effective.

BOX 3: Pan London Professional Support Unit

The Pan London Professional Support Unit provides resources for the professional and personal development of clinicians, and intervenes to help doctors who may be in difficulty.

A growing number of doctors applying for support from the unit went to medical school abroad. They satisfied English language requirements (IELTS test), but continue to find aspects of their professional communication challenging. The unit's team includes linguists who offer feedback through a one-to-one review of learning needs and specialists in clinical communication skills who support doctors in their cultural understanding and language development.¹⁴⁶ An evaluation by Oxford Brookes University found that their related coaching and mentoring programme provided an effective service.¹⁴⁷

Conclusions

There is a better understanding now than ever before of the differences in educational attainment between UK graduates, EEA graduates and IMGs, and between white and BME medical students and doctors in training. The evidence indicates that, across all stages of medical education and training, average attainment is lower for EEA graduates and IMGs and, to a lesser extent, for BME doctors, even if they are UK graduates.

Differential attainment begins before entry to medical school. It is linked to socioeconomic factors, gender and ethnicity, and the patterns of difference once in higher education are not exclusive to medicine, nor are differences explained by bias in the marking of tests.^{130, 148}

In valuing a diverse medical profession it is inevitable that students and doctors will begin their training programmes at different starting points.

The challenge

It is important that the GMC and others continue to explore the challenge of differential attainment and share the findings with all those responsible for organising, delivering and assuring the quality of medical education and training. Even at this relatively early stage it is clear that a number of specific challenges need addressing.

Being explicit at entry to a stage of education and training about what support students and doctors may need

Scores on entry tests for GP training can predict the likelihood of success in later exams. While we do not know whether this finding can be generalised to other specialties, it does fit with wider research indicating that future success is linked to previous attainment. Medical students, doctors and their supervisors need to discuss entry results at the beginning of programmes to identify strengths and areas for development in an open way, while recognising that all students and doctors will have met the required standards for that stage of training.

Being clearer about the way that wider environmental and institutional factors affect the progress of different groups

The research indicates that social capital – which may be affected by ethnic background, feelings of belonging, social networks and stereotyping – may influence differential attainment. These factors may be compounded by personal challenges outside of medicine, which may affect doctors' ability to engage in their training. The GMC has commissioned some qualitative research to help understand more about these issues, but a concerted effort will be required to pin down how these complex factors interact and how they can help identify the support medical students and doctors in training require.

Better evaluation and understanding of what works in supporting doctors and students

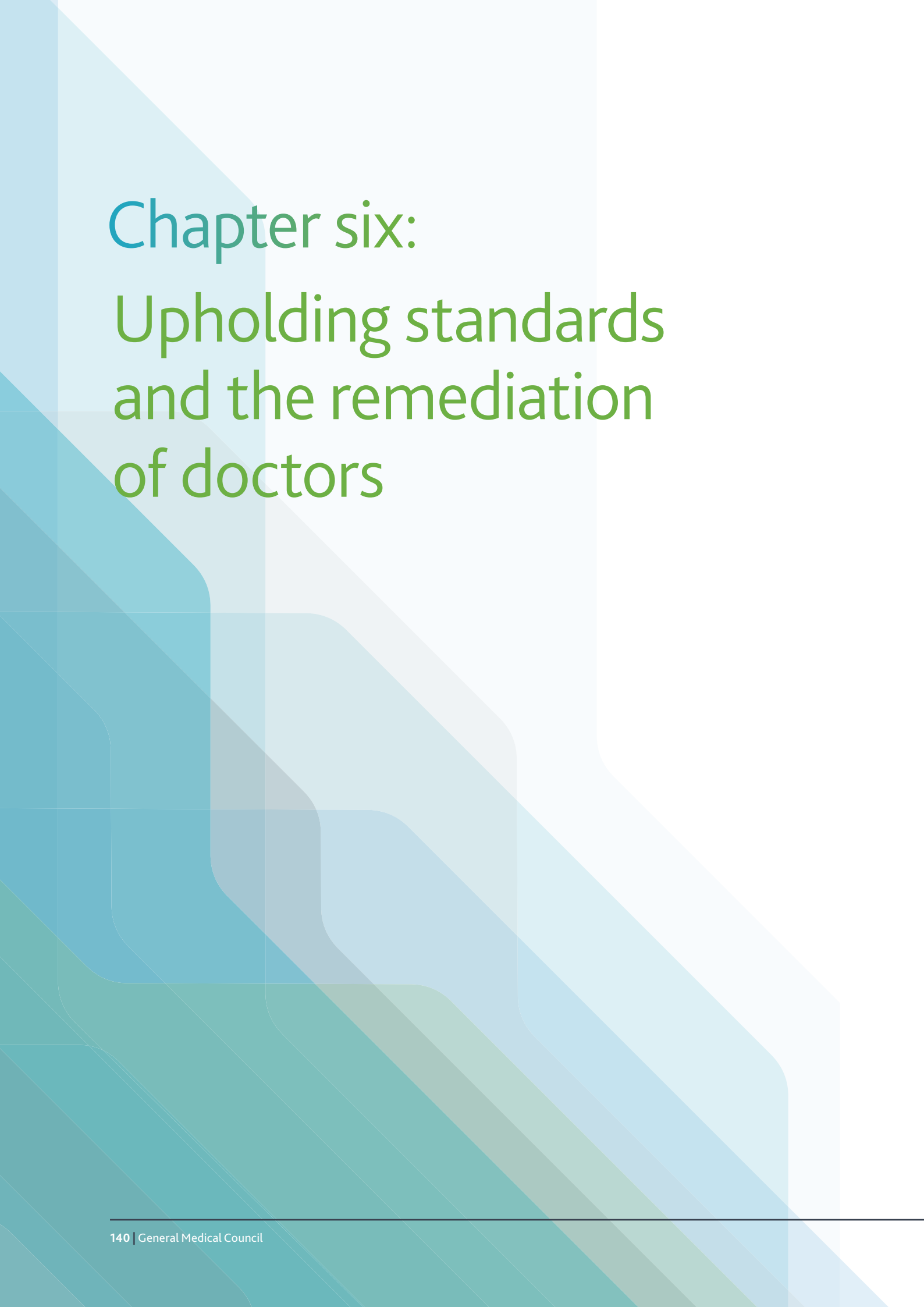
Patterns of differential attainment vary across deaneries and LETBs, but we do not know whether there are some areas or training programmes that have been able more effectively to narrow the differences or increase the attainment of doctors who enter programmes with lower scores.

Although there are some good examples of evaluating local support systems, more can be done to assess the impact and share knowledge across deaneries and LETBs so that we can develop a better understanding of how to identify barriers and provide support.

Equally, the Selecting for Excellence report published by the Medical Schools Council calls on medical schools to monitor and evaluate approaches to selection and support.¹⁴⁹

Keeping assessments under review and sharing information to help target local support

One of the important steps we have made this year is to identify that the patterns of differential attainment are reflected across different specialty areas of medicine and across different medical schools. Research has noted that differences in GP exam outcomes did not indicate bias in the clinical skills assessment and other research has indicated that differences exist in machine-marked exams.¹³³ But medical schools and colleges need to continuously review their assessments to make sure they reflect the competences required. They also need to use and share the information they have on these challenges to support deaneries and LETBs with developing effective support mechanisms.



Chapter six: Upholding standards and the remediation of doctors

Sanctions and warnings are designed to uphold standards, protect patients and help doctors remediate

Why remediation is important

The GMC's first responsibility above all others is to protect patients. In some cases it is necessary to suspend or remove a doctor's licence to fulfil that responsibility. However, in common with other health regulators in the UK and around the world, the GMC will try, wherever it is safe and appropriate to do so, to give the doctors who have not met the required standards the opportunity to remediate. When it is proven that they have remediated they can return fully to their vocation.

Enabling doctors to remediate while protecting patient safety is important for a number of reasons.

■ Retaining trained doctors

There are shortages of doctors, particularly in certain specialties^{150, 151, 152} and geographical areas.^{153, 154} The national systems in England, Northern Ireland, Scotland and Wales are under significant spending pressure.^{155, 156} It costs on average £485,390 to train a GP and £726,551 to train a consultant.¹⁵⁷ Retaining expensively acquired skills clearly makes sense.

■ Duty of care to doctor

The GMC's statutory powers are not designed to punish doctors, although of course their effect may be punitive. The aim is to protect patients and the reputation of the profession. That remains the most important part of the process and is a prerequisite for anything else. However, providing this is done the GMC has a parallel duty of care to the doctors that come under its scrutiny. That includes making sure that any action taken by the GMC, where possible, encourages and enables effective remediation. This is important for the doctors as well as their patients.

The concerns of this chapter

The full range of outcomes from a GMC fitness to practise process has been discussed earlier (see chapter 2). In this chapter we concentrate on those outcomes that are designed to encourage the doctor to reflect on their practice or which put in place arrangements to allow safe remediation. These outcomes are a warning, undertakings or conditions (see box 1).

This chapter explores whether the arrangements that have been in place are likely in practice to enable the remediation that they are designed to achieve. It identifies what conditions tend to make it more or less likely that remediation is successful. It also raises questions for further discussion about how the system might be improved and who should bear the costs of enabling remediation.

BOX 1: What are the GMC's sanctions and warnings?

A doctor is given a warning when the GMC needs to register concerns about their behaviour or performance to uphold the standards expected of all doctors working in the UK. It is designed to send a signal to the doctor and the wider medical profession that standards must be maintained. In legal terms it does not signify that the doctor's fitness to practise is impaired – were that to be the case a more serious sanction would be appropriate. Warnings are published on the online medical register for five years and must be disclosed to employers on request indefinitely.¹⁵⁸

When a doctor's fitness to practise is found to be impaired, the GMC and the Medical Practitioners Tribunal Service (MPTS) will seek to take action to protect the public or to maintain public confidence in doctors by giving the doctor one of four sanctions: undertakings, conditions, suspension or erasure.

If the GMC or an MPTS panel believes that the doctor can work safely under certain restrictions, then undertakings or conditions can restrict their practice or require them to do something, such as retrain.

- An undertaking is agreed between the doctor and the GMC, either at the end of an investigation or at an MPTS panel hearing. Undertakings remain in place until the doctor has remediated the concerns.
- A condition is imposed on a doctor's registration by an MPTS panel, rather than agreed with the doctor. These remain in place for a term agreed by the panel.

In practice the only difference between undertakings and conditions is that the former is agreed with the doctor and the latter is imposed. Both are published on the medical register and disclosed to employers indefinitely.

In the most serious cases where the doctor is not safe to work and is not able to remediate effectively, an MPTS panel can temporarily suspend or erase the doctor from the medical register, which means they are no longer able to work as a doctor in the UK.

In 2014, 131 complaints about doctors resulted in warnings and 158 complaints resulted in doctors having their practice restricted by agreeing to undertakings or having conditions imposed.

How warnings, undertakings and conditions are designed to work

Restricting a doctor's practice is appropriate when their practice is impaired but the GMC, or the MPTS panel, is confident that they can remediate and return to unrestricted practice. The doctor is responsible for making arrangements so they can continue to practise under the restrictions and demonstrate successful remediation. The GMC or the MPTS panel will remove the restrictions when there is evidence that the doctor is no longer impaired. When a doctor fails to remediate, an MPTS panel can take further action by increasing the restrictions, suspending their registration or removing (erasing) them from the medical register.

Given that the purpose of warnings, undertakings and conditions is not to punish, any sanction or warning should be the minimum needed to protect the public. However it is clear that aspects of the current system are not working as well as they should, and in particular questions are being raised as to whether doctors whose practice has been restricted can be better supported.¹⁵⁹

We know that a significant number of doctors who are referred to the GMC are already suffering from serious mental health issues, including depression and addiction. In addition, undergoing an investigation is itself stressful and doctors within the process are more likely to suffer depression, anxiety and suicide ideation.¹⁵⁹ In considering how to deal with the period when a doctor is under restrictions, it is important to establish whether these negative feelings continue once a case

formally ends and the doctor restarts practice with arrangements. As a first step though there is a need to find out more about doctors' experiences of practising with a warning, undertakings or conditions.

There are many organisations involved in investigating a doctor and with the process of returning to practice. Doctors investigated by the GMC are also likely to have been investigated by their own employer before, or at the same time, increasing the pressure and the stress they experience. For many doctors, once they have received a sanction or warning, it is these employers to whom they turn first to resume their practice as a doctor. In reality, we know that doctors can find it difficult to obtain the support they need to comply with restrictions but as restrictions are imposed only where they are needed to protect the public it can be difficult to devise alternative arrangements.

If warnings, conditions and undertakings do not work in the way intended, there may be missed opportunities to improve poor standards and for doctors to remediate. In the GMC's 2014 consultation on changes to sanctions guidance, most respondents felt the GMC should take more serious action where a doctor repeats conduct that led to a warning. In this context, it would be even more important that opportunities to help doctors improve their practice are not missed.¹⁶⁰

This examination of how warnings and restrictions work for medical practice in the UK may give useful insights to other health regulators in the UK and around the world. It is also helpful for the UK medical profession to consider whether there are lessons to be drawn from the research on this issue. The different approaches to giving sanctions and warnings around the world and in the UK are briefly described in box 2 (page 144).

BOX 2: The framework of sanctions and warnings around the world

The approach to giving sanctions and warnings varies across countries operating in different jurisdictions. Figure 50 shows this variation across ten countries.

Figure 55: Which countries give warnings and different types of sanctions?*, †

		Removal of right to practise medicine	Suspension	Admonition or warning	Fined	Public statement of blame
Egypt		✓	✓	✓	✓	✓
Germany		✓	✓	✓	✓	✓
Greece		✓	✓	✓		
India		✓	✓			
Italy		✓	✓	✓		
Nigeria		✓	✓		✓	
Pakistan		✓	✓	✓		
Poland		✓	✓	✓		
South Africa		✓		✓		
Spain		✓				

* In the cases of Spain, South Africa and India no evidence could be found on whether other types of sanctions than those marked in the table are used in fitness to practise cases. For those countries reliable evidence could only be found for the use of the sanctions indicated with a '✓' above.

† Data are reproduced from De Vries and colleagues' study.¹⁶¹

Use of sanctions and warnings by different healthcare regulators

In the UK there are nine statutory regulators covering healthcare professionals. Each operates a broadly similar model, but the outcomes of their fitness to practise processes vary. In particular, the proportion of complaints that result in a sanction or a warning, and the use of conditions and undertakings, varies (figure 56 below).¹⁶²

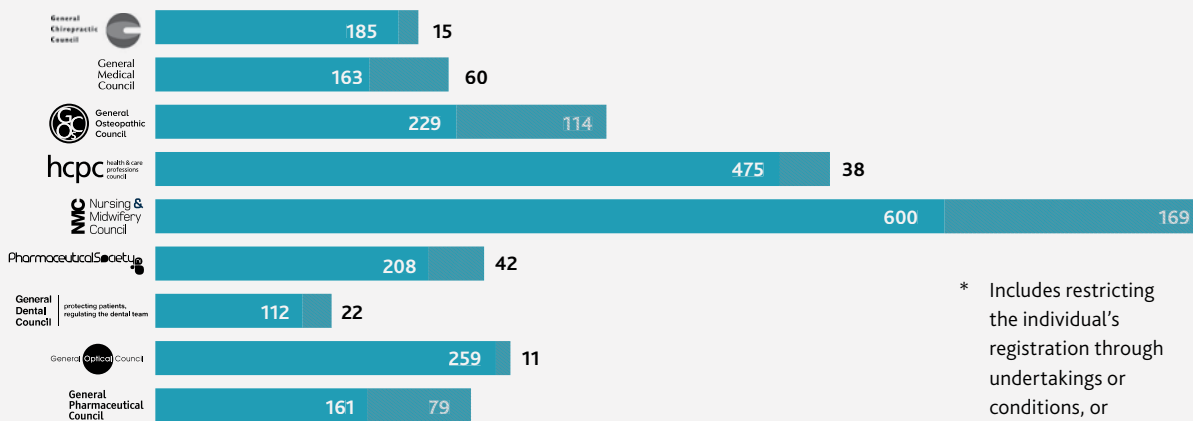
The warnings, undertakings and conditions are similar to those used by the GMC. For example, the Nursing and Midwifery Council can impose a cautions order for one to five years, which is broadly similar to the warnings issued by the GMC, and an order placing conditions on

a nurse's or midwife's practice for up to three years.¹⁶³ The General Dental Council can give a warning to a dentist without a public hearing, or dentists can have restrictions placed on their practice at a hearing.¹⁶⁴ If pharmacists in Great Britain are found to be impaired at a hearing, they can be given a warning or have restrictions put on their practice for up to three years, or they can agree to undertakings before a hearing.¹⁶⁵

Outside the healthcare profession, in England and Wales the Bar Standards Board can consider taking action if barristers breach its guidance.¹⁶⁶ After fitness to practise hearings, social workers in England can be given cautions and have restrictions placed on their practice.¹⁶⁷

Figure 56: Sanctions* and warnings given by UK healthcare regulators in 2014

- Sanctions or warnings per 1,000 investigated complaints
- Sanctions which restricted practice (conditions or undertakings) per 1,000 investigated complaints



* Includes restricting the individual's registration through undertakings or conditions, or suspending or erasing them from the register.

What issues help or hinder remediation and improving standards?

The GMC commissioned independent researchers to investigate what is needed for successful remediation and to identify obstacles doctors face in obtaining the support they need.

This small study approached doctors who had been given a warning, undertaking or condition between 2006 and 2013, and a range of employers.

152 doctors agreed to take part and were invited to complete a questionnaire; 99 doctors responded, of whom 42 had been given warnings and 57 had had conditions or undertakings imposed on them. 40 doctors and 21 employers took part in in-depth interviews. This is a small sample and doctors may be more likely to take part if they have had an experience that they are particularly motivated to share. The research therefore does not claim to give a representative picture of doctors who have been given a warning, undertaking or condition, but it does provide an insight into how these outcomes impact on the practice of some.

This chapter looks at the results of the research and we have included excerpts from some of the interviews. Broadly the research showed that:

- sometimes constraints imposed by the GMC sanction can obstruct doctors' attempts to remediate – there is a need for a discussion about whether some obstructions could be removed or alleviated and how this might be resourced
- remediation tends to be effective where both the doctor and their employer are willing and

able to make it happen – in those cases, the doctor was proactive and had the insight and willingness to change, and their employer gave them adequate support to do so

- doctors tend to fail to uphold standards or successfully remediate where they feel the process or the outcome (warning, undertaking or condition) is unjust, or where employers don't want or don't have the resources to continue to support the doctor.

What did doctors say had changed following a warning or a restriction?

The doctors surveyed by the researchers had a wide range of views about whether their experience had improved their practice (figure 57, page 147).

Many reported risk aversion and excessive caution in their work. While most disagreed that a warning had led to them being more likely to reflect on their practice, most with a condition or undertakings thought that it did make them more likely to reflect on their practice. Strikingly, there were large majorities of doctors disagreeing that their practice was safer (see discussion in box 3, page 148), and that their skill as a practitioner has improved.

It is difficult to understand purely from the responses of this sample whether warnings and restrictions on practice work to make doctors more careful, and to what extent this involves encouraging defensive practice. Perceptions of careful practice (where a patient is better cared for) as opposed to risk-averse or defensive practice (where a doctor's decisions do not better care for the patient) are often contested (see box 3, page 148).

Figure 57: Level of agreement with a list of statements about how having a warning or a restriction changed a respondent's approach to practising as a doctor

WARNINGS	RESPONSE				
	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
My skill as a practitioner has improved as a result of the outcome of my case	1	5	11	20	1
My practice is safer for patients now, as a result of the GMC outcome	2	2	13	17	4
I am more likely to seek the advice or opinions of other clinicians as a result of the outcome of my case	3	5	20	6	4
The outcome of my case has made me less confident in my own practice	7	13	12	5	1
I am more likely to reflect on my own performance and practice	7	8	15	5	3
I am sometimes excessively cautious in my practice now	8	10	13	5	2
I practise in a more risk-averse way now	11	8	12	4	3

RESTRICTIONS ON PRACTICE	RESPONSE				
	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
My practice is safer for patients now, as a result of the GMC outcome	3	10	11	18	3
My skill as a practitioner has improved as a result of the outcome of my case	3	7	17	17	1
I am more likely to seek the advice or opinions of other clinicians as a result of the outcome of my case	7	15	14	8	1
The outcome of my case has made me less confident in my own practice	8	11	15	9	2
I am more likely to reflect on my own performance and practice	9	23	7	4	2
I am sometimes excessively cautious in my practice now	12	15	11	7	0
I practise in a more risk-averse way now	13	17	10	4	1

BOX 3: How can we tell when a doctor has become safer?

A senior partner in a GP practice received a warning because she did not arrange for a patient with breast cancer to see a specialist or have a further review appointment, in accordance with the National Institute for Health and Care Excellence (NICE) guidelines.

The doctor has reflected greatly, writing a reflective essay, reviewing all previous referrals and the NICE guidelines, and arranging further training. The doctor believes that the warning has made them a more careful doctor.

'If I see somebody with any breast problem or something I'm not sure about, I do all I can to be doubly safe and leave less up to the patient. It's probably safer practice.'

However, another doctor, who was subject to a health case, warned about the risk that undertakings could lead to more defensive practice.

'I think everybody's getting more risk averse but I think that with undertakings over your head certainly would make me more cautious.'

Upholding standards and successful remediation may depend on whether doctors feel they were treated fairly

Insight is more likely if doctors feel they have been treated fairly

Doctors and employers both need to engage positively in the fitness to practise process for standards to be upheld and remediation to work. For doctors, insight and personal reflection are key and the research identified examples where this was happening. One Responsible Officer* in secondary care reported that a surgeon, who had received a performance-related warning from the GMC linked to a medico-legal report, had improved his standard of practice because he was willing to reflect and learn.

'He'd been slow in producing a report and the patient got disadvantaged. It didn't stop him being a really good surgeon. It was viewed quite severely but he took it in the context of what had happened, talked to us and said "I shouldn't have treated this person this way", and he's better for it. We were happy to keep him on.'

It could be that doctors who feel they have been fairly treated are more likely to show insight, but it could also be that insight into their circumstances may lead to doctors to view the fitness to practise process as being more fair.

Many doctors view the fitness to practise process as unfair and outcomes as disproportionate

Some doctors are better able to reflect on and understand where they can improve their practice and behaviour. But, as you might expect, the research showed that this is less likely where a doctor believes the outcome is wrong, especially if they question its fairness or see it as disproportionate. Many doctors who received a warning, undertaking or condition felt a strong sense of injustice because they felt:

- it should not have been given at all
- it was not a proportionate response to what had happened.

The fitness to practise process aims to give the minimum outcome consistent with patient safety and maintaining the reputation of the profession. However, a doctor's perception is what can determine whether reflection and remediation are likely.

* Responsible Officers are licensed doctors, and in most cases will be the medical director within a healthcare organisation. They have a key role in revalidation: they are responsible for making a recommendation to the GMC, usually every five years, about whether each doctor in their organisation should be revalidated. Responsible Officers also ensure that systems of clinical governance and appraisal in their organisation are working and are appropriate for revalidation.

The research suggested this may be affected by four elements:

- **Whether the doctor felt the process recognised the facts and information appropriately**

A feeling of injustice may depend on whether the doctor felt that the fitness to practise process recognised the facts and information appropriately. This may be the result of a reaction to the formal style of deliberation, or – in cases resulting in conditions – the doctor may have disagreed that their conduct amounted to impaired fitness to practise.

- **Whether the doctor felt the bringing of the case was just**

Some doctors thought the bringing of the case was unjustified, arguing that it had come about as the result of:

- professional rivalries
- a one-off incident that had failed to take into account an unblemished track record
- an unavoidable fade in skills after a period of suspension or sickness.

- **Whether the doctor resented the impact of a warning**

Many doctors felt a sense of injustice that, irrespective of the nature of the concerns, a warning remained on the online medical register for five years, and they must declare the warning for the rest of their career. One doctor described this as 'public corporal punishment' and an employer said it did nothing except to embarrass doctors. A doctor who received a warning in a misconduct case said:

'If you're warned you're warned, so why do you have to be continuously warned for five years. Why not just a year? Five years is a massive amount of time.'

- **Whether doctors feel their voices are heard in the fitness to practise process**

Doctors with a legal representative will be given advice on how to respond to the GMC's case against them. Nevertheless, whether represented or not, feelings of unfairness may arise in particular cases because a doctor has been persuaded by their legal representative to accept a warning or undertaking that they were not happy with.

A number of doctors interviewed said they had been advised to accept a warning or undertaking, making them feel that they had not been heard in the process and leaving a lasting psychological impact. Although undertakings must be agreed by a doctor, some of the doctors interviewed clearly felt that their choices had been limited, leaving them with a feeling of injustice. A doctor who agreed undertakings said:

'You agree the undertakings or you don't agree the undertakings. If you don't agree the undertakings you go to Manchester, to the panel. So while they call them voluntary, they're not. The solicitor's advice was if you go to panel, that they will put undertakings or conditions on. They'll put conditions on and to get the conditions lifted you have to go back to panel, so it's a much more difficult procedure so I agreed the undertakings.'

■ **Whether the outcome is felt to be appropriate**

Many of the doctors interviewed complained that the immediate and long-term effect of the warning, undertakings or conditions was not proportionate to the concerns. For these doctors, the stigma and shame lasted after the notice their warning or restriction was removed. A doctor who received a warning in a misconduct case said:

'I will never accept it, it's like breaking my dignity and honourability.'

If doctors felt that their career had been severely curtailed or ended because their employer or other factors meant they could not demonstrate remediation, they had a strong sense of unfairness. They felt that the ultimate outcome for them was disproportionate.

BOX 4: Do doctors with health issues feel supported by their employers and the GMC?

The research suggested that employers may be more sympathetic and supportive in cases about a doctor's health, which in turn supported successful remediation. Employers could make supervision arrangements more easily for doctors seeking clinical and psychological help for health-related issues than for those with performance issues. There was some praise for the medical supervisors in the GMC processes, but there were calls for a more pastoral and understanding approach.

At the beginning of 2013, the GMC set up a dedicated confidential emotional support service to assist any doctor involved in a fitness to practise case, provided on the GMC's behalf by the British Medical Association's Doctors for Doctors service. It provides emotional support throughout the case, pre-hearing visits to the MPTS so doctors can orientate themselves, and an independent supporter to accompany the doctor to any meeting with the GMC and for up to two days of their hearing. An independent evaluation of a two-year pilot involving 140 doctors* found:

- most doctors felt they got the right amount of support time
- doctors liked to talk to peers outside the case who were able to give feedback
- some doctors would have liked the option for support via Skype or face to face rather than just by telephone.

Separately, in 2014, the GMC commissioned an independent report into doctors who had taken their own lives while being investigated by the GMC. The report made a number of recommendations, including a review of the GMC's fitness to practise process from the viewpoint of vulnerable doctors.⁴⁶ The GMC accepted all of the report's recommendations and, in addition to the fitness to practise review, planned actions include reviewing the tone of correspondence with doctors under investigation to reduce unnecessary stress, reducing the number of health assessor reports where possible, introducing emotional resilience training for medical students, and increased understanding and mental health training for GMC investigators.

* The 140 doctors who accessed the service were asked to provide anonymous feedback and 10% responded.

Several factors affect how well employers support remediation

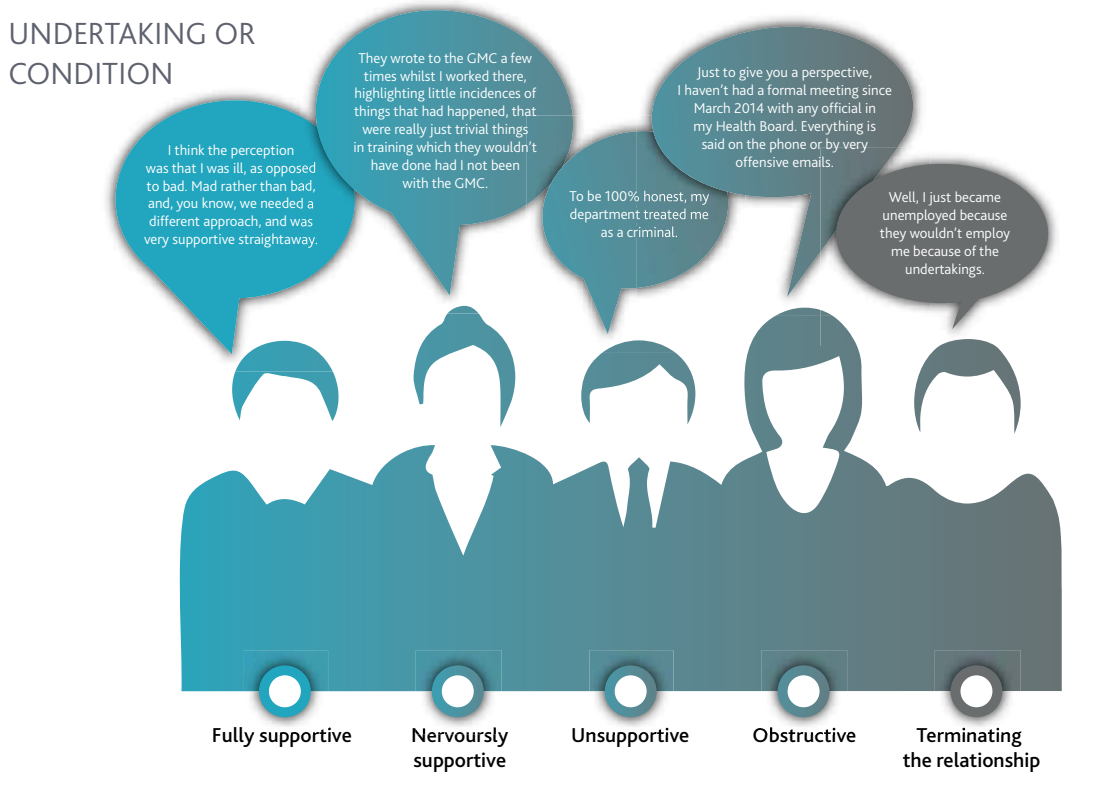
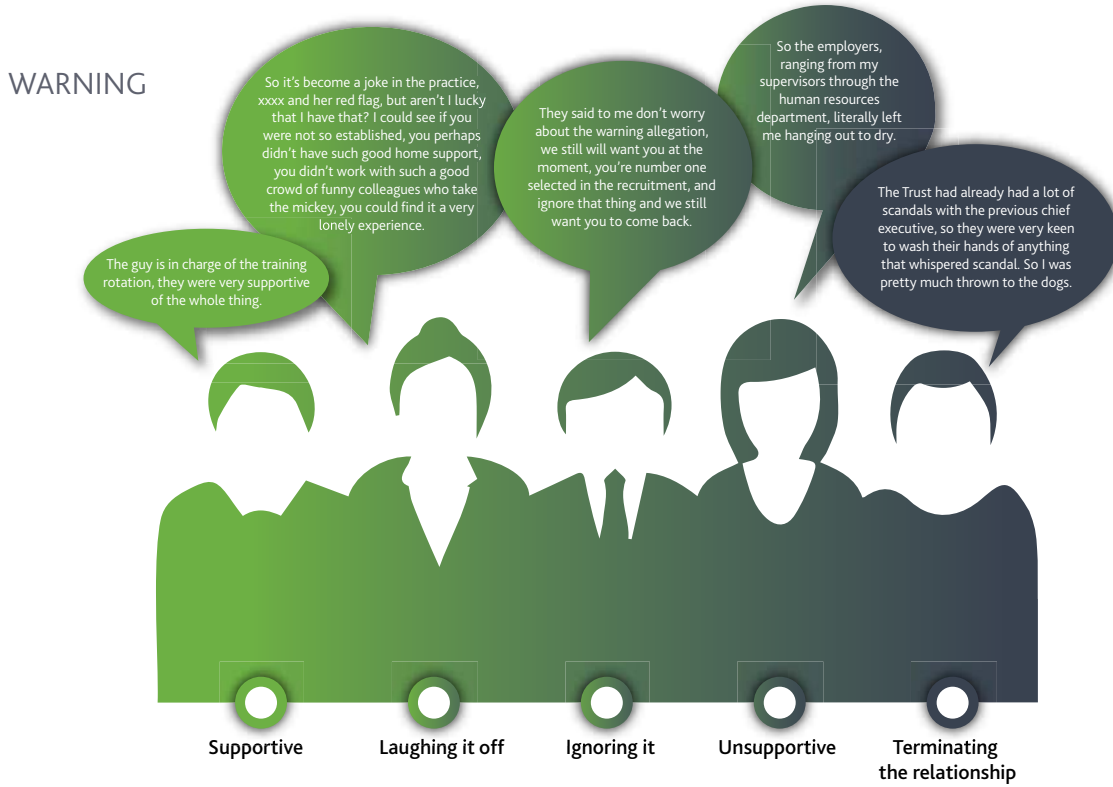
Employers' support, and their willingness and ability to make supervision and other arrangements for doctors to fulfil undertakings and conditions, is necessary for doctors to remediate. This section sets out why some doctors and employers think that doctors with warnings, undertakings or conditions are not given support and supervision.

The research showed that employers' support varied with:

- the issue that led to the doctor's warning, undertaking or condition
- the value of the doctor to them, both in terms of their position and attitude and in terms of their specialist clinical skills
- the potential reputational risk involved
- the practicalities of supporting the working restrictions, including the resources needed.

Figure 58 (page 153) shows the range of responses from employers for warnings, undertakings and conditions, taken directly from the research. One employer said undertakings and conditions are perceived as 'much more serious by everybody, much more of a damn nuisance'.

Figure 58: Doctors' views of the range of employers' responses to a warning or to an undertaking or condition



The issue that led to the warning, undertaking or condition

Where employers felt the issue was minor, did not relate to clinical performance, or was something the doctor could easily have fallen foul of, the employer's reaction tended to be more sympathetic and supportive.

Doctors in the study reported that employers were less sympathetic and supportive in cases involving poor behaviour, such as touching colleagues inappropriately, or in cases related to clinical skills where a patient died or had a late diagnosis. In some of these cases, doctors believed they were engineered out of their jobs, making it impossible for them to remediate.

The value of the doctor to the employer

Generally doctors were more likely to be treated supportively where they:

- had better, longstanding relationships with colleagues
- had a more established reputation in senior positions
- were totally open about their undertakings or conditions and how they came about (these doctors were more likely to report a positive reaction from both current and future employers)
- were more willing to reflect on their problems and to seek support from their employer
- had clinical skills that made them hard to replace.

This has implications for locums whose relationships with existing employers are naturally more tenuous and less well established.

Doctors with specialist clinical skills that are hard to replace were more likely to be supported, since employers have a stronger drive to preserve their relationship with the doctor. Specialties with shortages, such as emergency medicine, may be more likely to take on doctors with restrictions than those that are well staffed, although this is not the case in primary care where, despite some staffing concerns, it may be that the logistical problems involved in arranging supervision can make the supporting of undertakings or conditions inviable. Warnings had a less noticeable impact on these doctors' career than on those whose skills and experience are more common.

Doctors in training may not yet have acquired specialised skills that are hard to replace, so there may be a disproportionate impact on younger doctors. As such they may experience a greater impact than specialists or GPs. However, the research also showed that junior doctors were easier to arrange supervision for, and that support for remediation may be easier for them.

The potential reputational risk

Employers who thought there was a high reputational risk to their organisation, perhaps because of a high level of media or other interest, appeared less likely to support the doctor.

One Responsible Officer explained *'I think the reason people overreact is [when] it's reputational; they're worried about the reputation of the organisation understandably, and that's quite right.'* In some cases the doctor may be managed out, particularly in large secondary care organisations. Box 5 (page 156) sets out the concerns raised by doctors who believed their employers abused the fitness to practise process.

BOX 5: Doctors' concerns about abuse of the fitness to practise process

Around a quarter of doctors interviewed believed that the employer had used the fitness to practise process against them for inappropriate reasons. Several believed they had been reported to the GMC by malicious colleagues or employers who were manipulating the process for their own agendas. These included:

- avoiding costly contractual implications from ousting a GP partner from a practice
- seeking revenge on doctors for raising concerns
- ongoing bullying or victimisation in the workplace.

These doctors felt that, regardless of the outcome of the case, a doctor's reputation is sufficiently damaged by the process to have a negative impact on their career and ability to practise. The doctors also felt that the person making false allegations had nothing to lose.

In fact the GMC does already consider the context in which a complaint is made as part of considering all aspects of the individual circumstances of a case when deciding whether there are serious concerns that require action.

However, this assessment takes place as part of a full investigation which will almost always have an impact on the doctor involved, irrespective of the outcome of the case.

In 2014, the GMC commissioned Sir Anthony Hooper to undertake an independent review of how it deals with complaints about doctors who are whistleblowers. The review⁴⁰ recommended that organisations referring concerns to the GMC should declare whether the doctor has raised concerns about patient safety. Sir Anthony suggested that those who raise concerns may suffer, or believe that they suffer, reprisals from their employer or from colleagues. He said:

'The key to minimising the risk that the GMC unwittingly becomes the instrument of the employer in a campaign against a doctor is an understanding of the background to the allegation.'

The GMC has committed to change aspects of its fitness to practise process in light of the review, in particular to highlight whether a doctor has raised concerns about patient safety at an early stage.

The resources needed to allow doctors to practise with undertakings or conditions

Employers are confused about what arrangements they are responsible for making and paying for

The research suggested that doctors and employers understood that the doctor is responsible for remediating, but were not clear how far employers should go in organising and paying for arrangements to support this.*

Some employers admitted to being confused over where the duty of care lies for individual doctors working with undertakings or conditions. One Responsible Officer in secondary care saw taking on responsibility for a doctor with restrictions as part of their responsibilities within the NHS. Whereas others were frank that they would assess whether the doctor would be worth the effort and resources needed to support them to fulfil undertakings or conditions.

Arrangements can be expensive and practically difficult to make

Educational and clinical supervision arrangements, as well as practical arrangements to support practice, such as providing chaperones or monitoring prescribing, can be expensive and difficult for employers to put in place.

It can also be difficult for employers to find suitable supervisors; the individuals who are the best qualified to do it may not want to or may be too busy to take part. This is challenging as the affected doctors need this supervision to make sure they are safe to practise. An employer said:

'Unfortunately, it's always busy people who attract [...] jobs that they don't need, but you've got to do it right.'

* Undertakings and conditions involve one of three types of supervision: medical supervision for doctors with health-related restrictions (appointed by the GMC); educational supervision for doctors who need training as part of their conditions; and clinical supervision for doctors with performance-related conditions.

People can be unwilling to act as supervisors because of concerns about responsibility, risk, time commitment and lack of remuneration. They may also lack experience or understanding of the supervision process. Two different employers said:

'When you allocate somebody to be the clinical supervisor, they've probably never done it before. It's quite difficult for them to know what they should be doing and how they should be doing it...some clearer guidance on what's expected of people would be quite helpful.'

'The main problem is, you find that doctors will say "oh yes, I'll take that on" and when they find out what's required they basically say "oh no, I can't do that".'

Certain roles are more difficult to supervise – for example, consultants would not usually be accompanied by another senior doctor, making it harder to maintain confidentiality. GPs reported difficulties in meeting requirements: one had to move location to find a position in a training practice, and another had to move into a secondary care setting to have their work supervised.

Some of the doctors in the study said that locum agencies also found it particularly difficult to accommodate doctors with undertakings or conditions, given the nature of locum work and the high number of posts many locums undertake. Locum doctors said they needed to get reports on their performance in all posts, which would be time consuming for the agency to organise, supervisors to write and the GMC to review. A doctor who agreed to undertakings in a health case said:

'My case examiner was being constantly inundated with reports. She said she would get about 20 different workplace reports a month about me.'

Warnings and restrictions on practice felt to curtail a doctor's career

Almost a quarter of doctors with undertakings or conditions who were interviewed as part of the research were no longer practising. A number of doctors interviewed felt that the responses of their employers to the conditions or undertakings had contributed to their failure to demonstrate remediation and improvement.

One doctor said they did not want the humiliation of looking for a job with restrictions on their practice, and others had not been able to secure appropriate posts or even interviews. Many saw getting a new job as very challenging.

Some doctors believed that employers did not want to have to fulfil the supervisory requirements of undertakings or conditions, and they did not want to be tainted by taking on a doctor who had been investigated and given a sanction or a warning by the GMC. A doctor who agreed to undertakings in a case with multiple allegation types said:

'I lost my post as a consultant and I'm finding it difficult to get a new one. My impression is that as long as there's anybody else interested they'll take that one rather than a woman who's got this history with the GMC.'

And a doctor who agreed to undertakings in a health case said:

'I have absolutely no hope of finding another job with the undertakings current because you tell them at the point of application. I think they'd find an excuse not to interview me. It would be a lot harder at post-interview. Again, that's going to follow me no matter where I go.'

Some of the doctors believed that where an employer has a choice between two equally qualified doctors, one with a warning and one without, the employer will always choose the one without, having little or no understanding or recognition that a warning does not mean the doctor's fitness to practise is impaired. Others felt confident that they would work again, but no longer had all the career choices that were once open to them. Both views were shared by employers.

Most doctors with undertakings or conditions who had secured a job said they'd had to pursue a number of avenues. Success appeared to be dependent on the individual's tenacity and contacts who were willing to give them a chance.

Some doctors felt that they should not be obliged to share details of a warning when filling out a job application. They said they would still be transparent at interview, but they felt that being able to explain the nature of the warning and the reasons why it occurred might make it less likely that they'd be dismissed as a potential candidate.

How to work with others to make sure warnings, undertakings and conditions are successful

The aim of the system of sanctions and warnings must be to help doctors maintain high standards and to remediate where possible. The research has indicated that there are barriers which make effective remediation difficult which include:

- the doctor's perceptions of the fitness to practise process and the outcome
- the way that employers respond to warnings, undertakings and conditions
- the confusion about who is responsible for making and paying for arrangements to allow doctors to work with undertakings and conditions.

A number of suggestions were made during the research on ways to overcome or reduce the impact of these barriers.

Tailoring the restriction to the doctor's situation and care setting

Both employers and doctors called for an improved system that takes better account of each doctor's individual case, their needs, and the circumstances in which they will have to work with the undertakings or conditions in place. A doctor who received conditions in a case with multiple allegation types said:

'It's difficult when conditions are imposed on people and they are unfeasibly restrictive and it basically puts doctors in a situation where the conditions render them unemployable, so they can never demonstrate to a review panel that they've progressed. Then basically it's an erasure in everything but name. As long as they are workable conditions and they are tailored to the doctor's situation to make them feasibly imposed, I think they're a good thing.'

Several employers suggested that they would like more opportunities to discuss the undertakings or conditions with the GMC before they are put in place. This would allow them to set out the realities of the working environment and any existing requirements in place as a result of local action, so that the restrictions can be tailored appropriately. However, it is important that whatever suspension is put in place ensures that the public is protected.

Tailoring warnings to the nature of the concern

Doctors and employers were concerned about what they saw as a one-size-fits-all approach to warnings. They suggested that the wording of the warning and the length of time it stays on a doctor's record should differ depending on the severity of the issue, whether the issue is clinical or non-clinical, and whether the doctor has accepted the issue and improved standards or has refuted or denied it.

One employer suggested a suspended system, in which appraisals would be used to monitor progress and the doctor could be referred back to the GMC if they have not made changes. Another suggested that the warning could be removed from the online medical register early if the doctor has improved effectively.

Creating a more sophisticated range of warnings could improve the perceived fairness of the fitness to practise process, and prevent some of the disproportionate consequences reported by doctors. In 2014, the GMC consulted on proposed changes to guidance about imposing and agreeing sanctions and on the approach to take when doctors have apologised or shown insight into what happened.¹⁵⁷

Most respondents thought that the GMC should take more serious action where a doctor repeats conduct that led to a warning, and that publishing warnings for five years, as well as the approach to disclosing warnings to employers, was often disproportionate and should be considered on a case-by-case basis.¹⁶⁰ Following the consultation on indicative sanctions last year and this latest research, the GMC has recognised the need to reform the warnings regime and are developing a new model of warnings, including changes to the length of time a warning is published for. Another concern was the use of the word ‘warning’ itself, which might carry more negative connotations than are intended. However, to change this term would require a change in the *Medical Act*, as the term ‘warning’ is enshrined in the Act.

Taking a different approach to health cases as opposed to other types of cases

In the study, some doctors felt it was unfair and insensitive to handle health cases under the same fitness to practise process used for doctors with performance or misconduct issues. They felt that the GMC should take an entirely different and separate approach in health cases. A doctor who agreed to undertakings in a health case said:

‘I would have found it far more devastating to have felt that this was about conduct or integrity or medical capability, diagnostic capability, those kind of things. The one thing that kept me going was that actually it was about health and I’m going to get better.’

The GMC did operate an entirely separate system for health cases before 2004 but following significant criticism the current approach was introduced in November 2004. Some steps have already been taken to safeguard doctors with health concerns – for example, by making arrangements to protect the confidentiality of a doctor’s information about their health. Undertakings and conditions are published on the online medical register and disclosed to employers on request, but any information related solely to a doctor’s health is not published or shared unless requested by the doctors concerned.

This chimes with the finding from the consultation on sanctions guidance, where some respondents felt that the current GMC approach to disclosing warnings to employers was often disproportionate and should be considered on a case-by-case basis.¹⁶⁰

However, one doctor felt that the GMC should have been more transparent about their health case, since confidentiality about these issues can sometimes lead employers to assume the worst and avoid employing the doctor. Similarly employers can be frustrated by the emphasis on confidentiality about doctors’ health. Two different employers said:

‘The GMC keeps it utterly and absolutely top secret from everybody, keeps us out of the loop. They just discuss it with the doctor and redact everything. So we usually learn more from the doctor who tells us things like “the GMC said I can’t go back to work until I’m not taking this medication”. We’re worrying what’s happening but we can’t be told. Issues around health and lack of communication is a problem.’

‘This is a really tricky area that causes us deep frustration...and it’s a nightmare for the doctors.’

Improving dialogue with the doctor during our fitness to practise process

Doctors said they would like to see a softening of the GMC's language and communications, making it less legalistic in tone, and to have more opportunities for discussion during a fitness to practise investigation. The GMC has begun to introduce a range of changes to address this and other concerns. The major pilot project to hold meetings with doctors towards the end of an investigation has proved successful and the next stage involves exploring whether there is scope to talk to doctors at the start of an investigation.

Preventing employers misinterpreting warnings and restrictions

Many of the unintended consequences of warnings and restrictions appear to be caused by employers and the rest of the medical profession having an incomplete understanding of what warnings and restrictions are intended to mean.

Doctors felt strongly that employers do not differentiate sufficiently between warnings, which are given in cases where the doctor's fitness to practise is not impaired, and undertakings and conditions, which indicate that the doctor's fitness to practise is impaired. They felt that the GMC could do more to educate employers about this.

Employers acknowledged that doctors, HR departments and other colleagues are confused, particularly about undertakings. Some suggested that the consequences of warnings, undertakings and conditions could be reframed by changing the language to terms that are less judgemental and punitive. Two different employers said:

'I do think one of the biggest problems we often face is doctors understanding the GMC process, GMC conditions, GMC undertakings, what they actually mean, what the words actually mean.'

'There's something about the language of it all, what does warning really mean, what's the consequence of that? And even phrases like undertakings, what does that mean?'

Several employers suggested that the GMC should give them more guidance on how to deal with doctors with undertakings and conditions, particularly those who do not deal with many cases, and called for more, and clearer, guidance for doctors.

Clarifying who is responsible for, and who pays for, the costs of remediation

Employers called for guidance on their responsibilities to doctors with warnings, undertakings and conditions, and who should pay for the costs of remediation. The difficult issue of resources would benefit from further discussion with government, commissioners, medical royal colleges, and education providers.

Employers also suggested that the GMC should take a strong interest in whether they are providing the necessary support to doctors, and challenge trusts to demonstrate how they are dealing with cases appropriately. One doctor suggested that the GMC should write to the employer and the doctor every month to check the doctor is adhering to the undertakings or conditions. The GMC could then become involved if an employer is in some way blocking implementation.

Employers also suggested that the GMC could provide further practical support for those less experienced in dealing with sanctions. One employer suggested that the GMC might facilitate meetings between the doctor and their colleagues or manager, with a specialist team to help remediation and reintegration:

'Having that third party, who hasn't got a local bias on what's been going on, can be useful to bring some balance to the discussion...having a team that can facilitate that reconciliation is useful.'

Conclusions

The intention of warnings, undertakings and conditions issued as a result of GMC processes is to protect patients, while allowing doctors to remediate safely and return to full practice without impairment. The research reported in this chapter suggests that there is not universal understanding of this intention and that a shared understanding of this goal among those involved in a doctor's training and employment would be helpful. As long as restrictions and warnings are not working in the way they are intended, there may be missed opportunities to improve standards and professionalism.

There is a need for greater sophistication in handling warnings and restricted practice. The use of warnings, conditions and undertakings is common to a wide range of healthcare regulators – and to regulators of other professionals, such as social workers and barristers. The findings in this chapter are specific to doctors. They indicate that positive engagement between a professional and their employers has a beneficial effect on remediation, helping to allow a return to unrestricted professional practice. Where this relationship breaks down or becomes fractious, the professional may find it harder to remediate, and harder to return to practice. Identifying examples from other fields where the process has worked could be helpful in improving the situation for doctors.

The GMC is not responsible for establishing the arrangements doctors need to practise with undertakings or conditions. Indeed, in some instances it seems that no one takes responsibility for making sure that these arrangements are made, and there is no external support for employers where these arrangements are costly.

Although any conclusions from such a small study need to be tentative, it is clear that at least some doctors are unable to return to practice with the restrictions that have been imposed, despite their own best efforts. This raises a wider question of how remediation should be delivered and funded. There are those who argue that it is primarily a matter for the individual doctor who has not met the standards required. In some cases the employer may have dismissed the doctor or have good reasons why they do not wish to retain their services. However, others consider that enabling the doctor to remediate is a responsibility that employers, at least in the public sector, should undertake. The GMC's first duty must of course be the protection of patients and the wider public – but beyond that we should do everything possible to make sure that any restrictions imposed are practical. The GMC is looking at how the current system can be improved and in particular how it can work more closely with Responsible Officers to create restrictions that can be implemented both by the employer and by the doctor.

A note on data

Data in this report were primarily drawn from the information we collect when registering doctors, assuring the quality of medical education and training, and assessing doctors' fitness to practise.

Where inferences and comparisons are reported in the text, these have been statistically tested and were significant at a 99% confidence level ($p < 0.01$) except where indicated.

Percentages in all tables are rounded and may not add up to 100%.

Data for the analysis of the profession in 2014 refer to the medical register (known as the List of Registered Medical Practitioners), the GP Register and the Specialist Register on 31 December 2014. Data for the analysis of the change between 2010 and 2014 refer to the state of the registers on 31 December of each year between 2010 and 2014. Where data are aggregated over 2010–14, the number of doctors are taken as being the average number of doctors over those years. In figures or tables showing GPs and specialists separately, the very small number of doctors who are on both the GP and the Specialist Register are included in each category unless shown separately.

The analysis of joiners and leavers was based on our records of doctors who joined the medical register between 1 January 2013 and 31 December 2013 inclusive. We defined joiners as doctors who gained a licence to practise during the reporting year, but did not have one in either of the previous two years. We defined leavers as doctors who did not hold a licence to practise in the reporting year or the year after, but did hold one in the year before.

Information on why doctors left the register (figures 15–18, pages 48–53) comes from answers to an exit questionnaire, which is sent to all living doctors leaving the medical register except the small number erased following a fitness to practise investigation.

Fitness to practise data

Fitness to practise data for 2010–14 was for enquiries either received or closed between 1 January 2010 and 31 December 2014. The data were drawn from the GMC's database on 7 July 2015. For data referring to specific years, we used enquiries received between 1 January and 31 December of that year, except where we label an enquiry as being closed in that year.

Data for cases closed in each year were for enquiries closed between 1 January and 31 December of that year, including any appeal period for cases referred to an MPTS panel. 35% of complaints that originated in 2014 and were investigated (957 complaints) did not yet have an outcome when the data were drawn from the GMC database.

Case length is defined as the time from when the GMC first receives an enquiry to the time at which a final decision is made on how to conclude the investigation, either by a GMC case examiner or an MTPS panel.

Data on medical students and doctors in training

Data about medical students by academic year between 2010 and 2014 came from the medical schools' annual reports to us.

The number of doctors in postgraduate training programmes was estimated using data that local education and training boards in England and deaneries in Northern Ireland, Scotland and Wales provided in the 2014 national training survey – it was accurate on 24 March 2015. Where doctors were in training programmes that led to a range of specialties, we distributed the doctors using the number of training posts in each specialty. Where this information was not available, we used the proportion of each specialty on the medical register.

The 2015 national training survey was open from 24 March to 6 May 2015. Doctors in training were asked about the post they were in on 24 March 2015. The results were calculated using all valid responses.

Areas of practice

Some doctors have multiple specialties recorded on the Specialist Register. For the analysis, we have used their primary specialty. We separate out GPs and do not include them in tables of specialties.

For the analysis of doctors' specialties, primary specialties were grouped into 13 specialty groups according to the current list of specialties and subspecialties by approved curriculum. All older terms were matched to the specialty group that was the best fit; where that was not possible, they were assigned to the 'other specialty or multiple specialty' group – 187 doctors were in this group in 2014.

Data relating to the age of a doctor

There is a small group of doctors on the register with no date of birth recorded (2.2% in 2010 and 1.7% in 2014). In these cases, age was approximated by adding 24 years to the year since they gained their primary medical qualification.

Data relating to the ethnicity of a doctor

For the purpose of analysis, white ethnicity is defined as white British, white Irish and other white. Black and minority ethnic (BME) includes Asian or Asian British, black or black British, other ethnic groups and mixed ethnic groups.

We did not know the ethnicity of 16% of licensed doctors on the register in 2014.

Regional and country data

The index of doctors per population given in figure 19 (page 50) was derived using a denominator based on mid-2014 population estimates from the Office for National Statistics in the UK.

The regions of England are grouped according to regions defined by the Office for National Statistics, which were formerly called government office regions.

Countries are grouped into regions using the following groups.

Africa: Algeria, Angola, Burundi, Cameroon, Democratic Republic of the Congo, Côte D'Ivoire, Ethiopia, Gabon, Ghana, Guinea, Kenya, Liberia, Libya, Malawi, Mali, Mauritius, Morocco, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Somalia, South Africa, Sudan, Tanzania, Togo, Tunisia, Uganda, Zambia and Zimbabwe.

Central Europe, eastern Europe and Baltic countries (EEA): Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania and Slovakia.

Northwestern Europe (EEA): Austria, Belgium, Denmark, Finland, France, Germany, Iceland, Ireland, Netherlands, Norway, Sweden and Switzerland.

Southern Europe (EEA): Bulgaria, Croatia, Greece, Italy, Malta, Portugal, Slovenia and Spain.

Non-EEA Europe: Albania, Belarus, Bosnia and Herzegovina, Macedonia, Moldova, Russia, Serbia and Ukraine.

Middle East: Bahrain, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian Territories, Saudi Arabia, Syria, Turkey, United Arab Emirates and Yemen.

South Asia: Bangladesh, India, Nepal, Pakistan and Sri Lanka.

Rest of Asia: Afghanistan, Armenia, Azerbaijan, China, Georgia, Hong Kong, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Malaysia, Mongolia, Myanmar, Philippines, Singapore, South Korea, Taiwan, Tajikistan, Thailand, Turkmenistan, Uzbekistan and Vietnam.

Northern America: Canada and USA.

South, Central and Latin Americas and the Caribbean: Argentina, Barbados, Belize, Bolivia, Brazil, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Jamaica, Mexico, Montserrat, Netherlands Antilles, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Suriname, Trinidad and Tobago, Uruguay and Venezuela.

Oceania: Australia, Cook Islands, Fiji, New Zealand and Papua New Guinea.

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