General Medical Council

# The state of medical education and practice in the UK

## 2016

Working with doctors Working for patients

# Overview

## A challenging time

Patients should be assured that the standard of healthcare provided by doctors working in the UK remains among the best in the world[1, 2] though international comparisons are complex and difficult.[3] The international standing of British medicine and medical education is among the best,[2, 4] with strong contributions made from both UK and overseas doctors in every part of our healthcare service. The evidence from this year's report continues to show that the vast majority of doctors are not complained about to the GMC, and the introduction of revalidation has underpinned this, strengthening clinical governance and extending it to groups of doctors, such as locums, who in the past were left unsupported and in many cases unsupervised.

Yet, in spite of this positive conclusion, there is a state of unease within the medical profession across the UK that risks affecting patients as well as doctors. The reasons are complex and multifactorial, and some are long standing. The signals of distress are not always easy to interpret but they are unmistakable. This should not be seen as a counsel of despair but as a message to governments, employers, regulators, and the profession itself. The GMC is concerned because of the impact this might have on the professional standards for which we are responsible.

# Systems of healthcare under pressure

At the heart of this are systems of healthcare across the UK that are struggling with the impact of a growing number of people living with multiple, complex, long-term needs. This well-known challenge, combined with up to eight years of severely constrained funding,[5,6,7] has left many health services struggling to cope with rising demand,[8] a situation made significantly worse by the fragility of social care services, which in many areas is unable to provide support for anyone other than those with the most urgent needs.[9]

## Pressure on the healthcare systems

It is now clear that the acute sector in England is under intense pressure, with the prospect of £2 billion deficits in hospital budgets, and declining performance figures for access to emergency departments, planned operations and ambulance response times. The fact that the distress calls are not just from lobbying groups of one form or another, but from those responsible for running the services, underlines the gravity of the current position – NHS Providers has warned that the health service in England is 'under the greatest pressure in generations'.[10]

Scotland's official spending watchdog, Audit Scotland, has warned about declining standards of care due to budget cuts and has raised concerns about missed targets in patient care.[6] There has also been a 22% rise in the amount spent on locum services in Scotland, from £88.2 million in 2013–14 to £107.5 million in 2014–15. This is a sign of a system struggling to recruit the staff it needs and pointing to future workforce challenges.[6]

A succession of reports has exposed the pressures on other aspects of healthcare. The King's Fund's analysis of general practice points to a heavier workload as well as increasing complexity and intensity. It found a 13% increase in face-to-face contacts and a 63% increase in telephone contacts over the past five years.[11] The NHS throughout the UK is finding it difficult to recruit and retain enough general practitioners (GPs), especially those willing to undertake full-time clinical practice.[11] Unsurprisingly more patients are having difficulty accessing care and are less satisfied with their experience of GP services.[12]

## Some examples of areas of pressure

Mental health services are also facing major challenges [13, 14] and, as with GPs, the pressures are increased by significant shortages of personnel, including psychiatrists. In 2016, psychiatry has increased its training place fill rate in England, but 20% of places remain unfilled.[15] In Scotland there was a small increase in the number of round 1 core psychiatry places unfilled in 2016, but this represented only a small change in overall numbers (48 acceptances in 2016, compared with 50 in 2015, with six spaces more available in 2016).[16] The rate in Wales was reported by the Welsh Deanery in October 2016 as having 19% unfilled (17 filled out of 21 posts) in the first round of recruitment for Core Psychiatry.

Wales presents a similar picture of services under pressure – according to the Nuffield Trust. Some major procedures, such as coronary bypasses, have waits of up to twice as long as those in England, and on average Welsh patients spend around two days longer in hospital than those in England or Scotland.[17] There have also been reports of some cancellations of non-urgent elective surgery in Northern Ireland.[18]

There have been a succession of reports from independent organisations expressing concern about the current state of health services.[19, 20] It is not for the GMC to advocate a particular set of changes to make the system more effective or efficient nor to enter the debate about the right level of funding. However, the evidence suggests that the pressure on staff is growing and of course this can have an impact on patient care.

## A profession not at ease

The medical profession in Britain[21] has a long history of raising concerns that doctors are suffering from low morale but the levels of dissatisfaction now being expressed suggest that this is of a different order. The intelligence gathered by the GMC's Regional Liaison Service cannot be directly compared with previous years but doctors appear to be reporting higher levels of stress, depression and anxiety than before.[22]

A survey by the British Medical Association (BMA) in 2014 found that just one in five of doctors who joined the BMA's online research panel was satisfied with their career[23] while the 2015 National GP Worklife Survey found that GPs' job satisfaction was the lowest and their stress levels highest since the surveys began in 2001.[22] It should also be noted that doctors are not alone – a survey by the Royal College of Nursing found that nurses feel unsupported, undervalued and under pressure.[25]

Secondly, the pressures on the system are having a direct impact on the education and training environment, which is the foundation for future healthcare. Again this is not easy to quantify but there is evidence that, when services are under pressure, time and resources for education are the first to be sacrificed.[25]

## Doctors in training – anger and frustration

This year there has also been the added dimension of industrial action. The anger and frustration evident in the dispute between the Junior Doctors Committee of the BMA and the NHS in England suggest levels of alienation that should cause everyone to pause and reflect.

This is not just about terms and conditions or levels of pay. It is generally acknowledged that there are a host of underlying non-contractual issues, some of them long standing, that have helped to create this dangerous level of alienation among the next generation of medical leaders.[26, 27, 28] This should worry not just those of us close to the medical profession, but everyone concerned with the future of our healthcare system.

## Employers and doctors in training

Some of this demands the attention of employers. A survey of a group of doctors in training in England – from those in the first year of the foundation training through to those in the third year of specialty training or above – reported a lack of receptivity from their organisations. Most responded that they did not feel valued by managers (83%), by the chief executive and the organisation (both 77%), and by the NHS (79%). But the profession itself has nothing to be complacent about – nearly 60% did not feel valued by their consultants.[29]

The GMC's national training survey has increased in scope in recent years and now contains questions for trainers as well as doctors in training. It has been running in its current form since 2012 and this allows it to show trends which are being used to monitor and influence the quality of training. Medical education deans already use the report to identify areas where training is not meeting the expectations of doctors in training, which allows them to address concerns. It is, to all intents and purposes, a universal survey providing a powerful picture of postgraduate training in the UK.

The 2015 survey revealed that 83% of doctors in training throughout the UK rated the quality of experience in their post as 'excellent' or 'very good'. Yet within a matter of months, 98% of those doctors who responded to a ballot called by the BMA voted not only to take industrial action but also to support all-out action.[30] Although the questions asked were different the apparent disparity is something we will want to look at going forward.

The 2016 survey took place during the industrial action.[31] It once again paints a picture of a group who are broadly satisfied with their training but who are feeling pressure from staffing levels across the NHS, the 2016 survey revealed that 83% of doctors in training throughout the UK rated the quality of experience in their post as excellent' or 'very good'. While most appear positive about their experiences, the survey does reveal areas of real concern, not least the fact that between 50 and 60% of the doctors in training reported working beyond their allocated hours every week and more important that up to 25% found their working patterns left them sleep deprived on a weekly basis.

Some medical trainers are also concerned. As noted above, the 2016 national training survey included a new survey of postgraduate clinical and educational supervisors.[32] This had a very respectable 53% response rate. Over a third (36%) of those who responded said they are not always able to use the time allocated to them as a medical educator specifically for training. 14% reported that there were not always enough staff in their Trust or health board to make sure patients are treated by someone with an appropriate level of clinical experience. These findings not only reinforce the conclusion that education and training are being affected by service pressures, it also suggests some doctors in training are being asked to perform beyond their level of training.

## Enhanced monitoring

The GMC's enhanced monitoring process for addressing persistent concerns about the safety and quality of postgraduate training is relatively new. It is perhaps unsurprising then that in its first few years of operation the number of NHS Trusts and health boards with departments under enhanced monitoring has grown year on year. It is important to emphasize these are individual clinical departments where problems for doctors in training have been highlighted, not the whole hospital. During 2015, 39 new sites were placed in enhanced monitoring, an increase from 32 placed in enhanced monitoring in 2014. Five sites were taken out of enhanced monitoring over the same period. The total number of sites where we are helping doctors in training with enhanced monitoring of their training department at the end of September 2016 stood at 81.

Given the fact that there are literally thousands of hospital departments and GP training practices, the number remains relatively low and manageable, but in many of these cases the root of the problems lies outside education and with recruitment issues that leave rota gaps, over-committed consultants who struggle to provide adequate supervision, and in some cases services that are deemed ripe for reconfiguration.

Keeping this area of GMC work under close supervision will be vital in the weeks and months ahead – it may well be a bellwether for the rest of the system. It will also be important that organisations under enhanced monitoring are able to address the issues and have the process lifted.

## Lasting damage?

The number of doctors in training has remained fairly constant in recent years (see chapter 2), but there has been a recent trend for up to a third of doctors in their second year of foundation training (F2) not to proceed immediately to the first year of specialty training.

In 2012, 77.7% of F2 doctors who completed foundation training made an immediate application to the first round of specialty training places. In 2015, this fell to 65.7%, which equates to 582 fewer F2 doctors, though the reasons are unclear.

The GMC's national training survey found that 26.1% of F2 doctors intended to take a break from training after completing foundation training, and 3.5% said they were considering giving up medicine.[33] The vast majority of those doctors planning to take a break (86.5%) gave work-life balance as the reason – of that 86.5%, 47% cited burnout resulting from their clinical placements. This does suggest at least some foundation doctors are feeling what they regard as significant pressure, even if most still want to continue to work as doctors.

It has long been the case that not all doctors apply for specialty training immediately after completing foundation training – many take a break to work in roles that will help them improve their skills, both in the UK and abroad, or for personal reasons, such as having children. And many of those who do not apply straight away continue to work as doctors in the UK.

By 2015, 92.5% of the 2012 cohort (many of whom had taken temporary time out or worked abroad) were either back in specialty training or working as doctors in the UK.

We will therefore need to see whether this trend continues, and whether doctors are simply delaying their applications. For now, most specialties are recruiting at comparable levels in 2016 to 2015 and in Scotland there was a 27% increase in applications for post-foundation training. But this complex area certainly needs careful monitoring – a prolonged reduction in the supply of new doctors would of course lead to further system pressure and affect standards of care. The GMC therefore welcomes the recent government announcement that there will be an expansion by 1,500 of the number of UK medical students. Obviously these will not graduate until 2023 at the earliest and therefore will not be fully trained as GPs until 2028 or hospital specialists until 2033. In the interim, we will all need to think creatively about retaining new graduates, re-integrating those who have had time out, dissuading older doctors from retiring early, and recognising that 35% of doctors currently working in the UK qualified in the EEA or further abroad. The strong contribution of EEA and international medical graduate doctors to UK healthcare should not be underestimated.

## To value staff is to value patients

The link between staff and patient satisfaction is strong and has been long established – more recently work on the clinical engagement score has shown the vital importance of active involvement and shared objectives between institutions and professionals, not just for professional wellbeing but critically for the delivery of safe, compassionate care.[34]

Yet a strong theme in many descriptions of modern medical practice, especially among doctors in training, is a feeling of being undervalued. The anger around the dispute certainly owes much to this – in some ways this is hardly surprising given the programmes that move doctors in training to different geographical locations about every six months, sometimes with limited effort to make them feel that they belong. This has now become an urgent issue that needs to be tackled.

Other professions are also affected and say they are undervalued,[35] and pay restraint within the NHS, which means that pay fell behind inflation after 2010, may well play a part in this.[35, 36, 37]

But there are other factors peculiar to medicine. The welcome growth of transparency and the decline in patient deference, together with the changing relationship with other professions, have for many changed the way medicine is practised, while some regard the greater use of protocols and guidelines as reducing the scope for legitimate clinical autonomy.[38] Efforts to make the system more effective and responsive with all sorts of well-meaning incentives, such as quality and outcomes framework (QOF) payments for GPs and waiting time performance targets in emergency departments, have sometimes had unwelcome and unintended consequences,[39, 40] among them, again, a feeling that clinical judgement is being squeezed out.

# The regulatory challenge

## Fitness to practise and perceptions of the GMC

The GMC is conscious of its own responsibilities – fear of our disciplinary process remains and there is certainly a perception that more and more doctors are being referred. The reality is somewhat different – after years of rising complaints, the number of GMC investigations fell in 2015, a pattern that is more marked in 2016.

The number of cases that resulted in a sanction remains small – 355 in 2015. Nevertheless another 1,943 were investigated with no action taken, 383 received advice and 127 received a warning (see chapter 3 for further information). The fear of investigation, which can be very stressful, is real.

We are taking a wide range of measures to reduce the need for full-scale investigations while continuing to make sure patients are protected, as well doing everything we can to speed up the process and reduce the stress on all those involved, including patients and doctors. We continue however to be constrained by an out-of-date legal process that can only be transformed by legislative reform.

## Evolving the role of regulation

As our ability to use and analyse data has improved it has become clear though that there are areas of additional risk in medical practice that could benefit from greater attention. Moving towards a more risk-based model of regulation, which seeks to prevent harm from occurring instead of just waiting until it does occur, is a priority for health professional regulators both here in the UK and overseas.[41]

In 2015, we developed new guidance for doctors working in cosmetic surgery (issued in April 2016), including advice for the very vulnerable group of patients accessing this service.

We continue to be concerned about support for doctors coming to work here from overseas – as well as reviewing the entrance test,[42] we have rolled out our Welcome to UK practice course to many parts of the country.[43]

The general pressures on the system also present challenges for individuals and institutions seeking to maintain high standards. Our process of enhanced monitoring, which is in effect a form of special measures, only works if it includes the minority who are struggling, not the many who are doing their best in the difficult circumstances in which they find themselves. Likewise our fitness to practise procedures should not be used when the faults are systemic rather than individual.

## What next?

There appears to be a general acceptance that the system cannot simply go on as before – there does need to be early and concerted action.[44, 45, 46, 47] Everyone wants a health service that is efficient, effective and compassionate. We all want staff working in the health service to practise in an environment that helps them provide an excellent standard of care and where they are able to raise concerns and are valued for their skills.

The GMC is the independent regulator of the medical profession across all four countries of the UK and we have a role to play in offering our own solutions and working with others to help. We are committed to doing what we can and below we have set out some of the areas where we believe we can make a contribution.

1 Revaluing doctors in training – the GMC stands ready to work with doctors in training and their organisations, such as the BMA, employers, education funders and providers, medical royal colleges and others with an interest in this area. There is a need for a UK-wide conversation, to understand fully the views of doctors in training as well as the perspective of employers, educators and others. From this should emerge a detailed action plan to reform the way education and training are organised so that they match the needs and expectations of the doctors and the healthcare systems they serve.

2 Allied to the above initiative, there is a need to engage on what professionalism means for the doctor in the 21st century – the GMC's initial programme of work in this area, supported by a wide range of organisations, concludes at the end of 2016 but there is a strong appetite to take this topic forward. The Chief Medical Officer's report in Scotland[49] highlighted a number of issues that require attention as does the Welsh government programme 'Prudent Healthcare'.[49] Northern Ireland Medical and Dental Training Agency developed a skills framework for all specialty doctors in training which included a mandatory Being a Professional module for all initial years specialty doctors in training, run in partnership with the GMC.

3 The GMC will continue to develop a risk-based model of regulation, using its own data and those of others, including on-the-ground intelligence, to identify areas of risk within medical practice and to help develop with others ways to address those risks and reduce levels of harm.

4 Traditionally, regulators of professionals have not regarded workforce planning as falling within their remit. But given the huge responsibility the GMC has for medical education and the growing value and volume of the data we hold, it must be right that we work with and support those engaged in workforce planning throughout the UK. And we must play our part in making sure the system produces doctors with the right knowledge, skills and standards of behaviour to serve patient needs in the years ahead.

5 The healthcare systems throughout the UK need to build on the progress that has been made with revalidation. Later this year the GMC will receive the independent review we have commissioned by Sir Keith Pearson, which will set out proposals for taking forward this important patient safety initiative. In this area, as in others, the goal must be to make regulation as light touch as possible while maximising its impact. Working with other regulators, including those focused on the system such as CQC and Healthcare Improvement Scotland, we should also seek to reduce bureaucratic requirements without losing gains in patient safety.

Doctors play a vital role in our society and this report recognises that the care they provide is among the very best in the world. But they are under intense pressure as are the health services within which they work. We must continue our work with doctors, patients and with health services across the UK, to make sure that we play our part in maintaining high quality healthcare systems.[50]

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Read the report and tell us what you think about our findings at **www.gmc-uk.org/somep2016**

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# Contents

# An information resource

## For *The state of medical education and practice* readers

**This year we are again publishing online a large set of reference tables to accompany *The state of medical education and practice 2016*. 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/somep2016.**

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 are publishing 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 five 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 2011 to 2015.

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 group.

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 2015. 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 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 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')
- disability.

Separate sheets of tables are presented for each of the 14 training programme specialty groups, such as foundation, psychiatry and general practice.

## 4 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 2015/16.

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.

## 5 Fitness to practise

These tables are based upon registration data combined with management information arising from the GMC's fitness to practise work. Data are presented for each of the years 2011–15 and for the whole period 2011–15, 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 2011–15 are shown.

When interpreting these tables, it should be borne in mind that several doctors may be involved in a single fitness to practise process, and one doctor may be involved in several processes during the period reported. About half of the tables count the number of particular fitness to practise processes or outcomes, and about half count the number of doctors involved in those processes or outcomes. The tables cover fitness to practise 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.

# Executive summary

Our sixth annual report on the state of medical education and practice in the UK sets out an overview of issues that feature prominently in healthcare. It examines the GMC's data relating to the changing medical register and explores the patterns of complaints about different groups of doctors.

## Overview

### A challenging time

This year's report comes after a prolonged period of upheaval in the health sector, with growing service and financial pressures in the National Health Service (NHS) and a long dispute over new contracts for junior doctors in England.

Growing numbers of people living with multiple, complex, long-term needs, combined with severe financial and staffing pressures in many areas of the healthcare sector, have left many health services struggling to cope with rising demand.

### A profession not at ease

Many doctors are feeling the pressure, and need to be supported at all levels. Work environments under pressure can have an impact on professional standards and the wellbeing of doctors. The level of dissatisfaction among doctors seems to be higher than ever before.

### Pressure on doctors in training

The 2015 survey revealed that 83% of doctors in training throughout the UK rated the quality of experience in their post as 'excellent' or 'very good'. Yet 98% of those doctors who responded to a ballot called by the British Medical Association (BMA) voted to take industrial action. We are working to do more to listen to doctors in training and identify their concerns. There is a risk that doctors in training might leave the profession if the pressure is too great.

### What next?

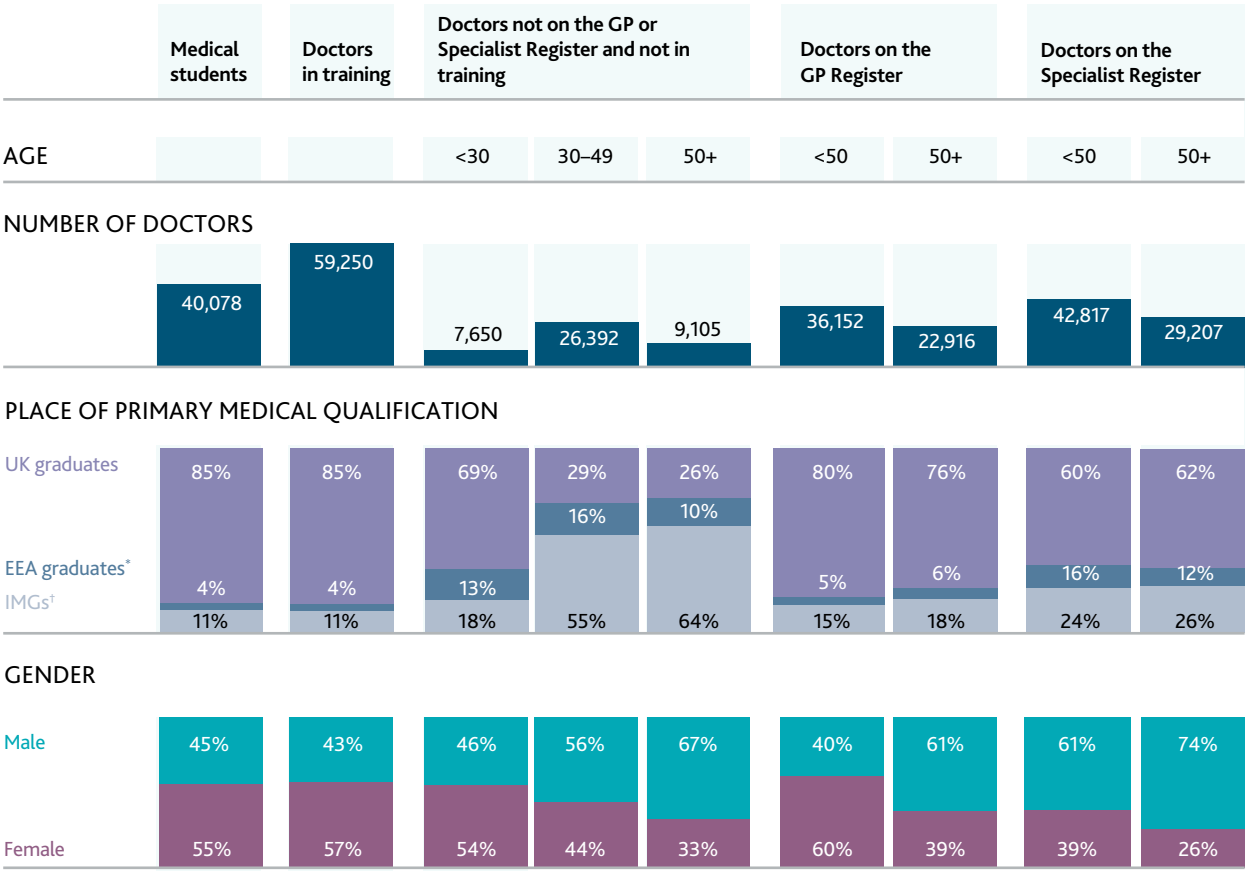
We are the independent regulator of the medical profession across all four countries of the UK and are committed to doing what we can to ensure good professional standards in this difficult environment, and have set the areas we believe we can deliver on. These include:

- making sure education and training matches the needs of doctors and healthcare systems
- engaging with what professionalism means for doctors in the 21st century
- developing a risk-based model of regulation
- engaging with workforce planning
- building on progress with revalidation and making sure regulatory bureaucracy is minimised.

# Our data on doctors working in the UK (Chapter 1)

In this chapter we show an overview of doctors on the UK medical register, looking at age, gender, place of primary medical qualification and ethnicity. We look at patterns within specialties and changes to the workforce, as well as the revalidation outcomes of different groups of doctors.

**Figure 1: Demographic characteristics of licensed doctors on the register and medical students in 2015**




GP = general practitioner.

* 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.

† International medical graduates (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.

## Number of licensed doctors remains steady

Although the register continued to grow, with an 11% increase in the period 2011 to 2015, the trebling of the number of unlicensed doctors, largely following revalidation means the number of doctors licensed to practice in the UK has remained steady, increasing by only 1% over the period.

## An already ethnically diverse profession becoming more so

The ethnic diversity of the profession appears to be increasing. Over the period 2011–15, there was a 22% increase in the number of specialists who described themselves as black and minority ethnic (BME)* against an 8% increase in specialists generally, and an 18% increase in the number of GPs defining themselves as BME, against a 2% increase in GPs generally.

Among GPs and specialists who were UK graduates, a higher proportion described themselves as BME (18% and 16% respectively) than in the UK population overall (13%).

## Fewer doctors coming from abroad to work in the UK

The fact that certain specialties rely on non-UK qualified doctors has implications for workforce planners, as the UK is reducing its reliance on doctors who qualified outside the UK over time.

Of the doctors licensed to practise and work in the UK, fewer were from abroad – 10% fewer IMGs and 2% fewer EEA graduates in 2015 compared with 2011. The number of UK graduates had increased by 6%.

The trend for increasing numbers of EEA graduates to come to the UK from southern European countries, such as Italy, Spain, Greece and Portugal, has reversed, with an 11% decrease in 2014–15 after several years of increase.

## The growth in female doctors is slowing

Previously we had predicted that the proportion of female doctors would pass the 50% mark by 2017 in the UK, but this may now take longer.

Our analysis this year found that the proportion of registered female doctors grew from 43% in 2011 to 45% in 2015. But the growth in younger female doctors slowed compared with the growth in younger male doctors – the proportion of male doctors under 30 years old increased by 20%, from 2011 to 2015, while that of female doctors increased by only 6%.

Some countries in the UK had already reached gender parity: female licensed doctors made up 51% and 50% in Scotland and Northern Ireland respectively. England had 46% while Wales had 44%.

## Update on revalidation

In 2015, almost 70,000 doctors had a recommendation approved by the GMC. Of these doctors 83% were revalidated, while the remainder were deferred. A tiny proportion – 209 doctors – failed to engage. Doctors connected to a locum agency for revalidation were more likely to be deferred than those connected to most other organisations.

* BME includes Asian, black, mixed ethnic groups and other ethnic groups.

# Medical students and doctors in training in the UK (Chapter 2)

In this chapter we explore the changes in the numbers of medical students and doctors in training, looking at who the doctors were (age, gender, ethnicity, place of qualification) as well as the make-up of specialties where doctors were training and trends in part-time working in training posts.

Data in this section are shown from 2012 onward, when the national training survey was updated.

In 2015, there were 40,078 medical students at UK universities in 2015, a reduction of 3% since 2012.

## The demographic make-up of doctors in training is changing

Doctors in training were increasingly likely to have gained their medical degree (primary medical qualification) in the UK, with UK graduates making up 85% of all doctors in training – up from 80% in 2012. Of those doctors in foundation training, 96% were UK graduates.

In particular, in 2015 compared with 2012, there were fewer doctors with an Asian ethnicity in training, mirroring the broader trend that of all licensed doctors non-UK graduates were now less likely to work in the UK – including south Asian doctors, who had historically made up a large part of the workforce.

## The specialties in which doctors are training are gradually changing

Psychiatry – as well as obstetrics and gynaecology – saw a drop of 10% in the number of doctors in training between 2012 and 2015. Over a third (41%) of psychiatrists in training were non-UK graduates – the highest proportion of any training programme.

# Complaints about doctors (Chapter 3)

In this chapter we analyse complaints received by the GMC in 2015 and how these complaints were resolved. We also examine trends over the period 2011–15 and changes in the source of these complaints.

## A slowing of a rapid increase in complaints

In 2015, there were 8,269 complaints about doctors' fitness to practise – a 7% reduction since 2014.

Complaints about doctors rose sharply in the two years to 2013, after which they gradually reduced, falling in both 2014 and 2015.

## Around one in seven complaints from the public result in investigation

The majority of complaints (68%) came from the public in 2015. This group also accounted for the largest number of complaints in previous years, peaking in 2013 and declining in the following two years. In 2015, 9% of complaints came from other doctors, 6% from employers and 6% from self-referrals.

The percentage of complaints leading to a full GMC investigation varied substantially, depending on the source of the complaint. Just 15% of complaints made by the public in 2015 met the threshold for a full investigation by the GMC, compared with 80% of complaints made by employers, 51% made by the police and 31% made by other doctors.

## Outcomes of investigations have remained fairly constant

Of the 2,808 investigations concluded in 2015:

- 5% led to warnings
- 6% led to conditions or undertakings
- 7% led to suspension or erasure.

More than two-thirds were closed with no further action and 14% were closed with advice given to the doctor.

# Groups of doctors at higher risk of complaints and investigations (Chapter 4)

In this chapter we examine the relative risk of a doctor being complained about, investigated and receiving a sanction or a warning. We also consider variations in risk by register type, source of complaint, age, gender and allegation type.

## Risk of complaint and investigation by register

Only 3% of licensed doctors were subject to a fitness to practise complaint in 2015. This rose to 5% for those on the GP Register and was lower for those on neither register.

## Complaints and investigations are not homogeneous

Some groups of doctors were more likely to have complaints from particular sources and were more likely to be investigated in relation to certain issues than others, as shown in figure 3.

## Cases about health, criminality, honesty and fairness are more likely to end in a sanction or a warning – and are more likely to come from sources other than the public

Nearly half (45%) of cases stemming from concerns raised by employers involved health, criminality, honesty or fairness, while these types of cases accounted for only one in six (16%) of cases arising from complaints from the public.

These types of cases had a much higher probability of resulting in a sanction or a warning than those involving only issues of clinical competence, which accounted for nearly a third (30%) of investigations arising from public complaints, but less than one in ten (9%) of cases stemming from concerns raised by employers. More than half (55%) of all cases involving a doctor's health resulted in a sanction or a warning compared with 4% of clinical competence cases.

**Figure 2: The percentage of doctors complained about and having their complaints investigated, by type of doctor, 2015**

| | % complained about | Number complained about | % of complaints investigated |
|---|---|---|---|
| | | | 10 20 30 40 50 |
| **Doctors on the GP Register** | 5% | 2,755 | 27% |
| **Doctors on the GP and Specialist Registers** | 4% | 51 | 24% |
| **Doctors on the Specialist Register** | 3% | 2,319 | 30% |
| **Doctors not on the GP or Specialist Register and not in training** | 2% | 819 | 48% |
| **Doctors not on the GP or Specialist Register and in training** | 1% | 405 | 47% |
| **Total** | **3%** | **6,349** | **32%** |

## Risks of complaint, investigation and warning or sanction for different groups of doctors

Less than one in a hundred doctors actually received a sanction or a warning between 2011 and 2015.

The risk of receiving a sanction or a warning was higher for older and male doctors. Doctors aged 50 years and over were consistently complained about more than younger doctors – and this was true of women and men alike for doctors on the GP, Specialist and neither register. A higher percentage of investigations about younger doctors led to sanctions or warnings.

Compared with white doctors who graduated in the same area of practice, doctors who graduated outside the UK and BME doctors were more likely to receive a sanction or a warning from the GMC.

**Figure 3: Proportion of male and female doctors by age who were complained about, had the complaint investigated and received a sanction or a warning during 2011–15**

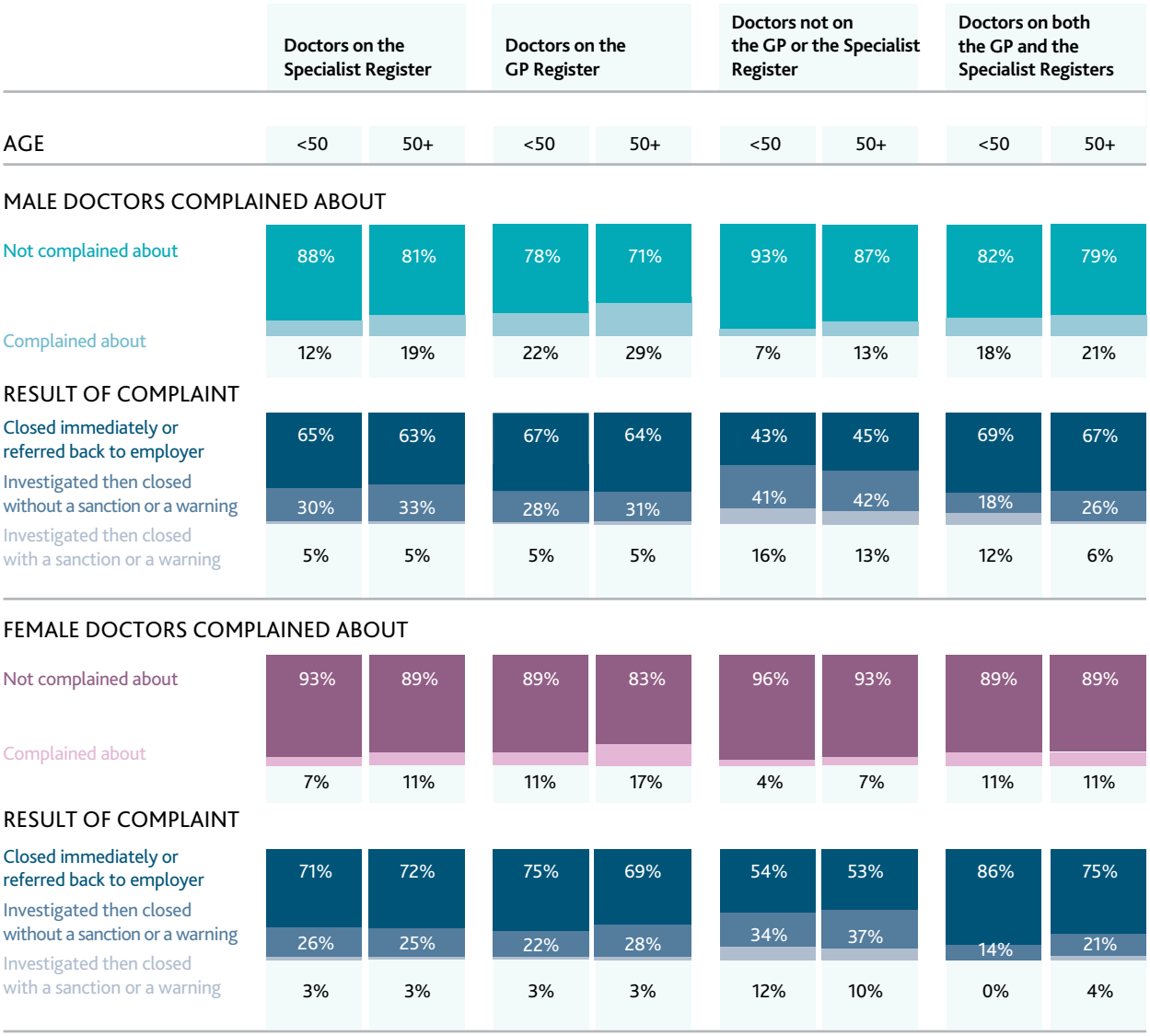
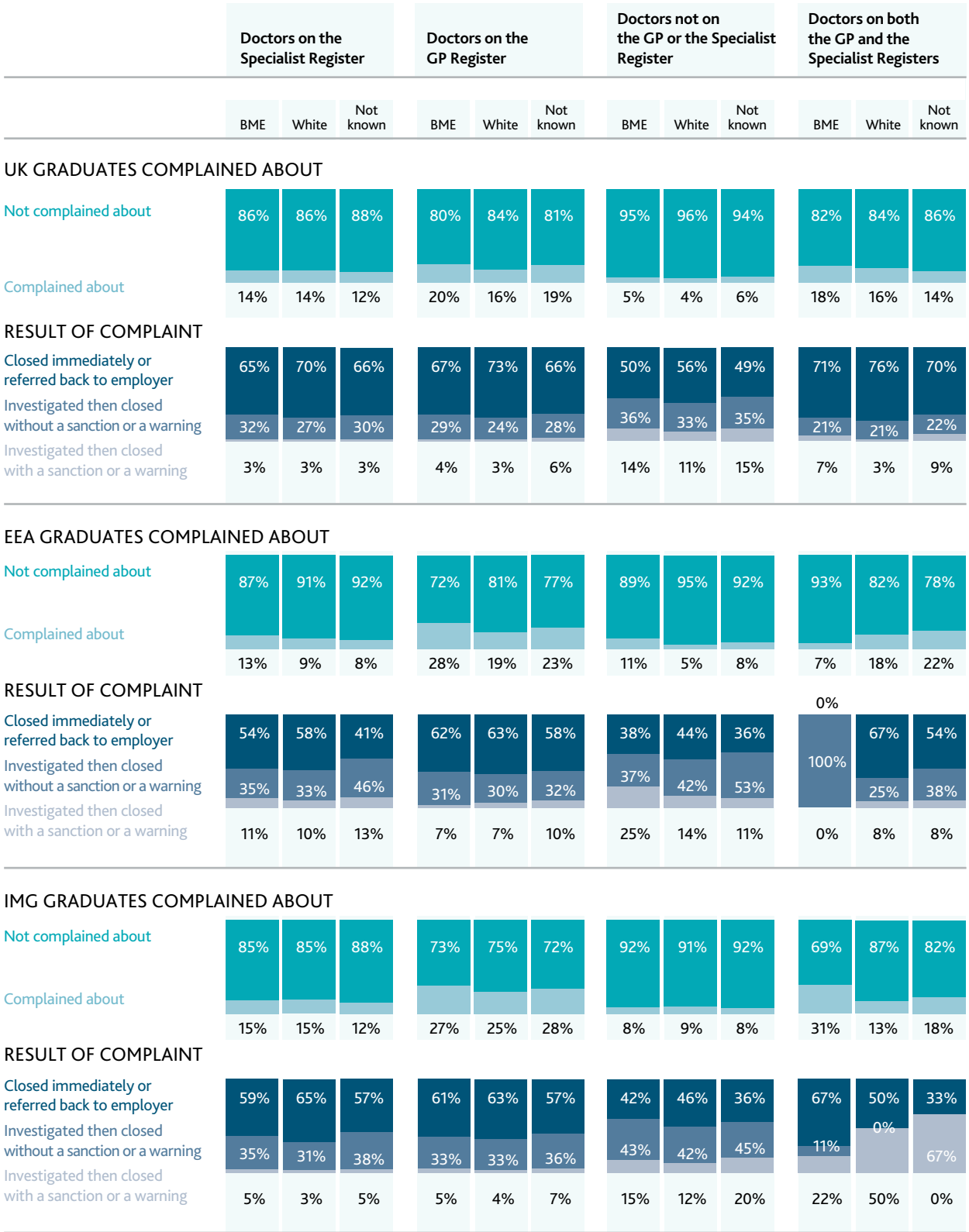


**Figure 4:** Proportion of doctors who were complained about, had a complaint investigated and received a sanction or warning during 2011–15, by place of primary medical qualification and ethnic group



# Regional differences in the types of doctor (Chapter 5)

In this chapter we look at how the workforce of GPs and specialists, and doctors who were neither, varied between different parts of the UK and regions in England.

## Doctors broadly reflect their local ethnic population

The profession as a whole is more ethnically diverse than the UK, but broadly countries of the UK with higher ethnic diversity have higher diversity in their doctors.

Northern Ireland and Scotland had a very low proportion of doctors who were BME or non-UK compared with the UK average, while England had the highest proportions of both. The English regions with the highest proportions of non-UK doctors were the West Midlands and the East of England (40% each).

## Wales has very slightly older GPs

The age profile of doctors varied relatively little between the four countries of the UK. Wales had the oldest profile of GPs, though the difference was small: 43% of GPs in Wales were aged 50 years and over compared with a UK average of 39%.

Wales had fewer GPs than Northern Ireland, despite similar population density. This difference may indicate capacity issues or lower use of GPs in Wales. The Welsh government is planning a campaign to increase GP numbers.

# The future of healthcare regulation in the UK (Chapter 6)

## Why change?

The GMC's role in protecting the public must be shaped by the expectations of the society on whose behalf we regulate, while at the same time retaining the consent of the doctors. Regulation is changing and the GMC must be involved in these changes.

## Increased expectations of regulators

The GMC must support doctors in the work that they do. The best way to do that is not by taking action when things have gone wrong and patients (and often doctors themselves) have already been harmed. It is by directing our resources to support good practice and, where we can, mitigate the risks of harm occurring.

## Promoting professionalism

We seek to instill the standards of behaviour for good medical practice. Our proposals for a new medical licensing assessment support this approach, while allowing medical schools the flexibility to go beyond our requirements if they wish to do so. The proper aim of regulation should go beyond the assurance that practising doctors are not 'bad', and promote the sort of professionalism that most of us would want to take for granted.

## Preventing harm

The work of our Regional Liaison Service and offices in Scotland, Wales and Northern Ireland is a good example of engaging with the profession to promote good practice across the profession. The same is true of our work in medical education and training, and revalidation.

## Risk-based regulation

Following the work of the Better Regulation Executive, regulators have been increasingly focused on making sure their regulatory activities are guided by an understanding of risk in the regulated area. Risk-based regulation offers a more proportionate regulatory response to problems, and it enables regulators to put in place interventions that can help prevent risks materialising as actual harms.

Improved data and intelligence sharing will help regulators target their activities more effectively. It should also mean that the demands on individual doctors and the wider healthcare system to provide the same or similar data for multiple agencies can be reduced because data can be collected once and used for multiple purposes.

## The future shape of regulation

The UK government's latest initiative to examine the future of professional regulation is therefore welcome. It promises to consider the purpose of regulation, alongside issues of autonomy, efficiency and cost effectiveness.

# Chapter one:
# Our data on doctors working in the UK

In 2015, there were 273,794 doctors on the UK medical register. Of these, the vast majority, 234,740, were licensed to practise in the UK. The remaining 39,054 were non-licensed.

# The number of licensed doctors remains steady, but the number of non-licensed doctors on the register is rising

## The number of licensed doctors has remained fairly constant since 2011

To maintain a licence to practise, doctors have to be revalidated as being fit to continue practising every five years. The process of revalidation, which was introduced in 2012, encourages doctors to decide whether they need to retain the licence for the work that they do. The number of non-licensed doctors was expected to grow as a result, mainly from older doctors who were no longer practising, but also from those involved in teaching or research who were no longer using the licence. Many doctors who have given up their licence to practise have maintained their registration – this means that they do not have to take part in revalidation, but still have a connection to the medical profession. We provide further data on revalidation at the end of this chapter.

Although the register continues to grow, with an 11% increase in the period 2011-1515, the trebling of the number of unlicensed doctors, largely following revalidation, means that the number of doctors licensed to practise in the UK has remained steady, increasing by only 1% over the period (figure 5). The growth in the number of non-licensed doctors has now slowed slightly, but still increased by 29% in 2015, which was expected.

As figure 6 shows, between 2011 and 2015 there has been more than a three-fold increase in the number of non-licensed GPs and specialists and a slightly lower (two-and-a-half fold) rise in the number of doctors on neither the GP or specialist register (excluding doctors in training).

**Figure 5: Number of licensed and non-licensed doctors on the medical register 2011–15**

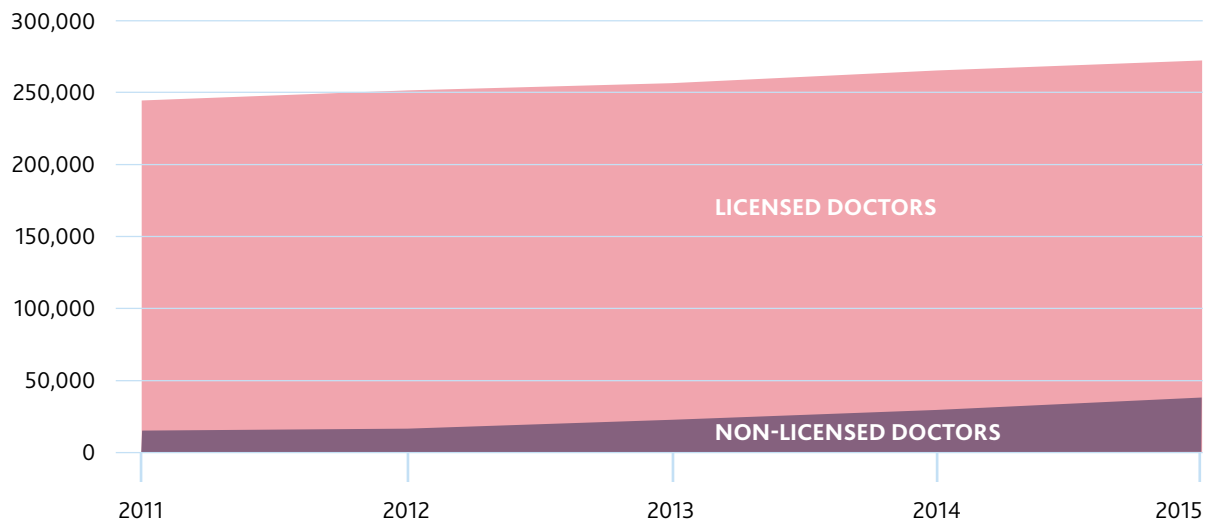
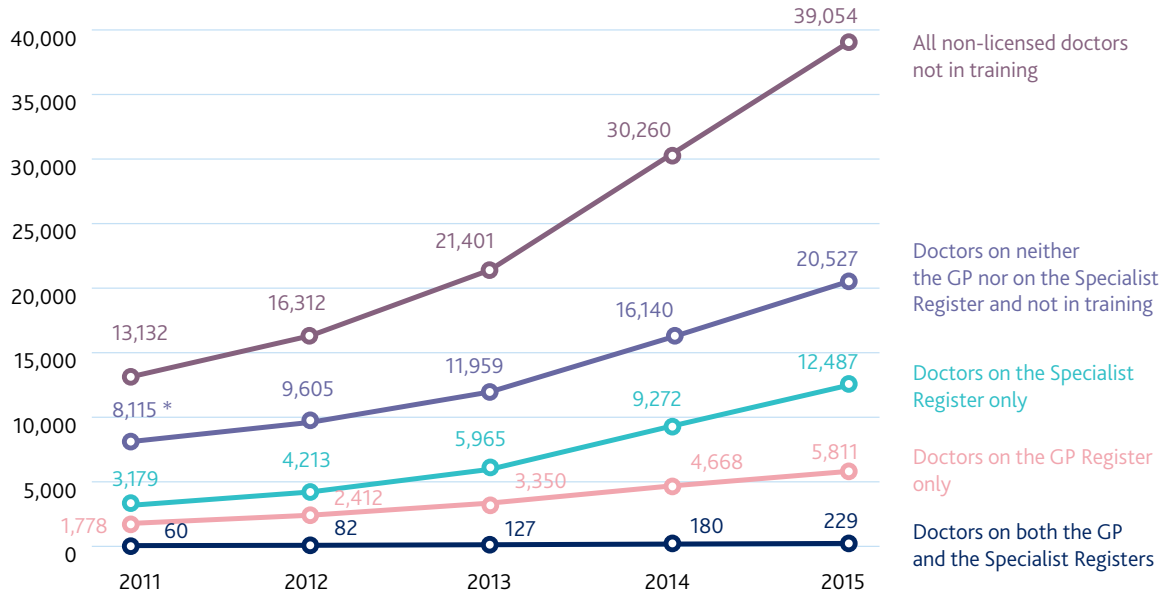


**Figure 6: Number of non-licensed doctors not in training on the medical register in 2011–15**

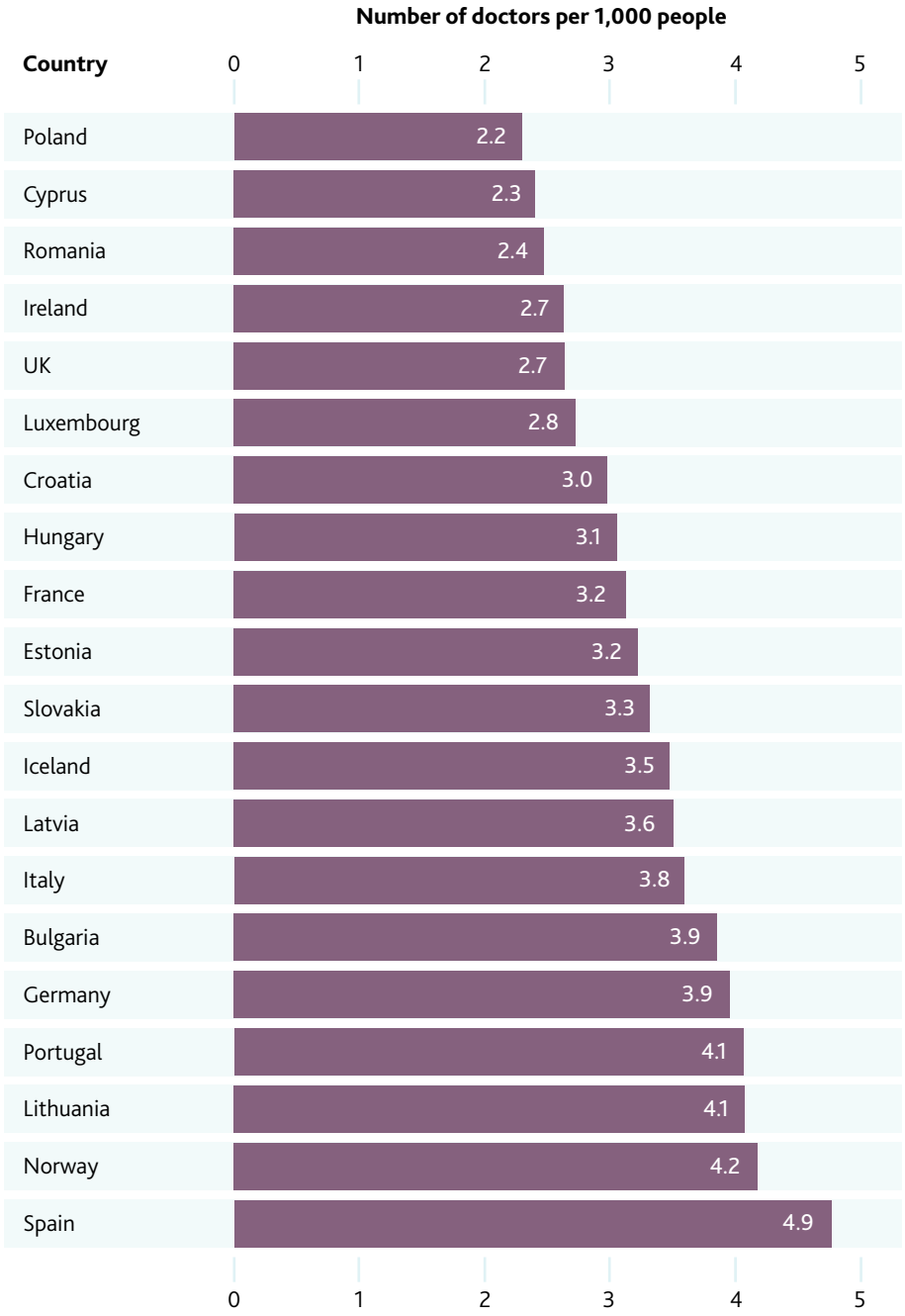



## The UK has a lower ratio of doctors per head of population than some other EEA countries

The World Bank holds data on the number of doctors per 1,000 people in each country.[51] The most complete recent data set for European countries comes from 2012 and figure 7 shows that, in a comparison of 20 EEA countries, the UK has the fifth smallest number of doctors per 1,000 people.

* This figure is extrapolated from other data. Subsequent data points use data only made available from 2012 onwards.

**Figure 7: Ratio of doctors to people across selected countries in the EEA, 2015**



# A more female and older workforce with more part-time working

The relatively low number of doctors in the UK relative to the population, compared with the rest of Europe, and the lack of significant growth in the number of licensed doctors, may in part contribute to the pressures described in the overview of this year's report. At the same time, supply might also be affected by an increase in the proportion of doctors working part time. The ageing of the doctor population may also be a cause for concern in the future as demand and expectations continue to rise.

## Moving towards parity between men and women

The proportion of female doctors is edging closer to making up 50% of the register, with a 45% share in 2015 compared with 43% in 2011. The number of female doctors on the register has grown by nearly twice as much as the number of male doctors. Among those aged 50 years and over, there has been a 28% increase in female doctors between 2011 and 2015, compared with a 10% increase in men.

However, growth in the number of younger female doctors is slowing relative to male doctors. The number of male doctors under 30 years increased by 20% (from 13,681 to 16,481) – faster than the number of female doctors of this age, which increased by 6% (from 21,616 to 22,822, see figure 8). This means that the proportion of the workforce that is female will increase, though potentially by less than seen before. The proportion of doctors in training who are female is 57%

## The number of older doctors is increasing at nearly one-and-a-half times the rate of younger ones

The number of older doctors (aged 50 and over) on the register increased by 15% compared with an increase of only 10% in those aged 30–50.

**Figure 8: Changes in the gender and age of doctors on the UK medical register between 2011 and 2015***

| | | 2011 | | | 2015 | |
|---|---|---|---|---|---|---|
| | | % total | Number of doctors | % change | % total | Number of doctors |
| **TOTAL** | | **100%** | **245,893** | **11%** | **100%** | **273,794** |
| **GENDER** | | | | | | |
| **All doctors** | Male | 57% | 141,336 | 7% | 55% | 150,778 |
| | Female | 43% | 104,557 | 18% | 45% | 123,016 |
| **AGE (YEARS) AND GENDER** | | | | | | |
| **Under 30 years** | **All** | **14%** | **35,297** | **11%** | **14%** | **39,303** |
| | Male | 6% | 13,681 | 20% | 6% | 16,481 |
| | Female | 9% | 21,616 | 6% | 8% | 22,822 |
| **30–49 years** | **All** | **57%** | **139,695** | **10%** | **56%** | **152,982** |
| | Male | 31% | 76,626 | 2% | 29% | 78,242 |
| | Female | 26% | 63,069 | 19% | 27% | 74,740 |
| **50 years and over** | **All** | **29%** | **70,901** | **15%** | **30%** | **81,509** |
| | Male | 21% | 51,029 | 10% | 20% | 56,055 |
| | Female | 8% | 19,872 | 28% | 9% | 25,454 |

## Increase in number of doctors working part time

According to the ninth BMA cohort study (published in May 2016), there has been an increase in the number of doctors working part time.[52] 119 of the 421 doctors (28%) surveyed said they were working part time in 2013–14, up from 23% in 2012–13. This was the case for both female and male doctors, although it remains true that more female doctors work part time (41% in 2013–14) than male doctors (12% in 2013–14). GPs are more likely to be working part time than other specialties. These cohort findings are also reflected in The King's Fund's work on this area.[53] At this time we do not hold data on whether doctors are working full time or part time.

* Data are for all registered doctors, including those who do not have a licence to practise.

# Where doctors come from is changing, but the proportion of doctors from each part of the world on the register changes only slowly

## Where doctors gained their primary medical qualification remains relatively constant and the growth in EEA graduates declined in 2015

The proportion of all doctors on the register who graduated from different parts of the world has remained fairly constant between 2011 and 2015: in 2015, 64% of doctors were UK graduates, 11% were EEA graduates and 26% were international medical graduates (IMGs).

This is despite a large increase in the number of EEA graduates from a relatively small base number of EEA doctors – a 24% increase, compared with only 12% for UK graduates and 5% for IMGs between 2011 and 2015. The growth in the number of EEA graduates is now slowing – a 2% increase in 2014–15, compared with 7% in 2013–14, 6% in 2012–13 and 6% in 2011–12.[54]

When looking only at doctors who have a licence to practise, this trend is stronger – the number of licensed EEA graduates decreased by 8% during 2014–15. Overall, during 2011–15, the number of licensed EEA graduates decreased by 2% and the number of licensed IMGs decreased by 10% (figure 9).

Figure 9: **Source of licensed doctors on the register 2011–15**

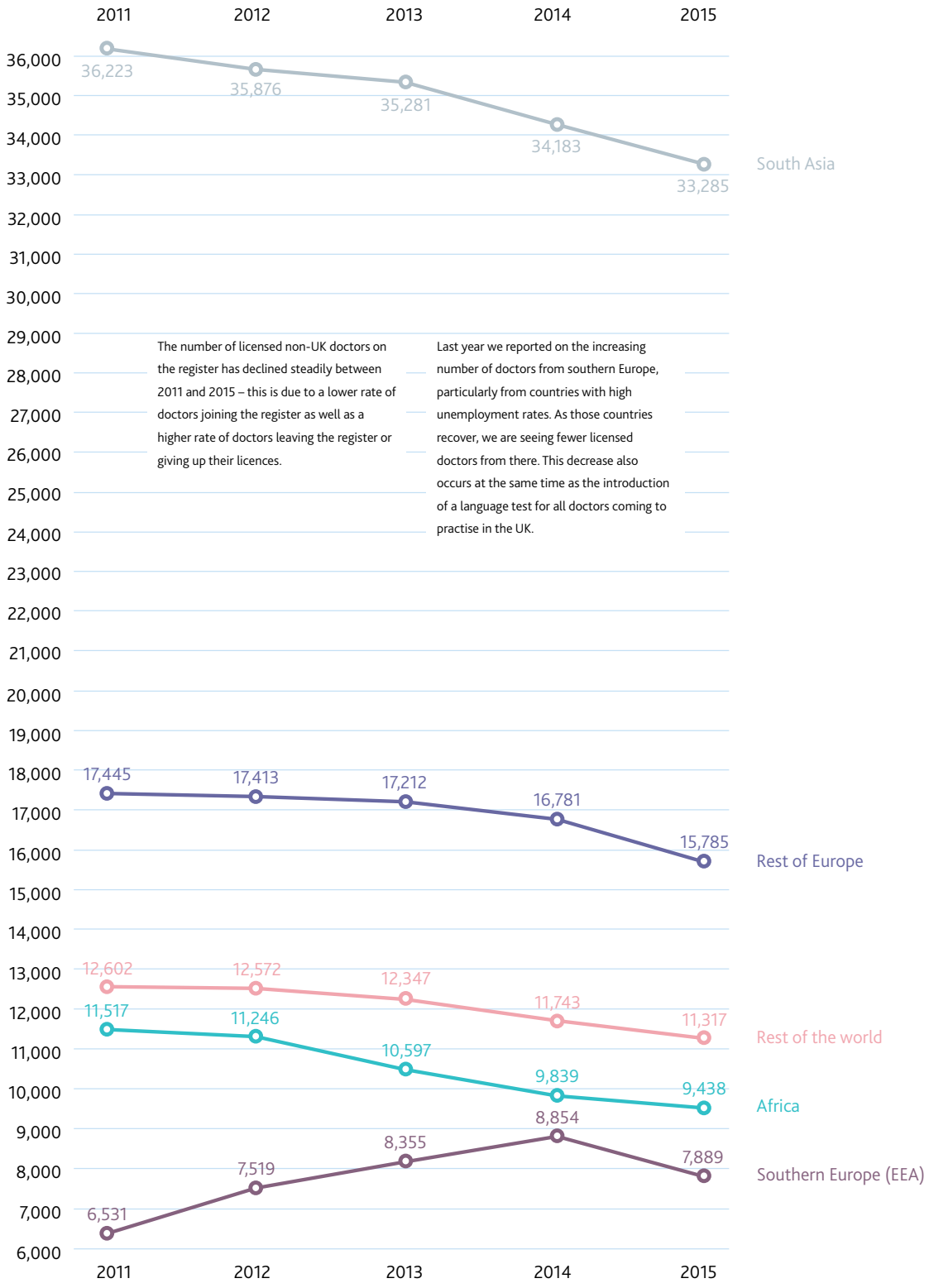
| | 2011 | | | 2015 | |
|---|---|---|---|---|---|
| | % total | Number of doctors | % change | % total | Number of doctors |
| **GRADUATES** | | | | | |
| **All** | **100%** | **232,761** | **1%** | **100%** | **234,740** |
| UK | 64% | 148,443 | 6% | 67% | 157,026 |
| EEA | 10% | 22,451 | -2% | 9% | 22,039 |
| IMGs | 27% | 61,867 | -10% | 24% | 55,675 |

Most world regions (including Europe) contributed fewer doctors to the register in 2015 than in 2011. Only one non-UK region has more doctors on the register in 2015 than in 2014 – the category 'rest of Asia', which includes Thailand, Vietnam, Indonesia and others.

A large proportion of licensed doctors gained their primary medical qualification in south Asia, but the number of doctors from this region has declined by 8% during 2011–15.

Figure 10 shows the regions of the world where doctors with a licence to practise in the UK gained their primary medical qualification.

**Figure 10: Number of doctors with a UK licence to practise in 2011–15 by region of the world* where doctors gained their primary medical qualification**




* Please see data notes, page 104, for a breakdown of which countries are in each region.

## Fewer doctors are coming from southern Europe

In last year's report, we showed the increase in the number of graduates from southern Europe (Spain, Portugal, Italy and Greece) during 2011–13.

This trend now appears to be reversing (figure 10). There has been a sharp increase in doctors from southern Europe giving up their licence, so the number of licensed doctors decreased by 11% between 2014 and 2015. This indicates that the recent influx of doctors from countries with higher unemployment may have peaked and now be reducing.

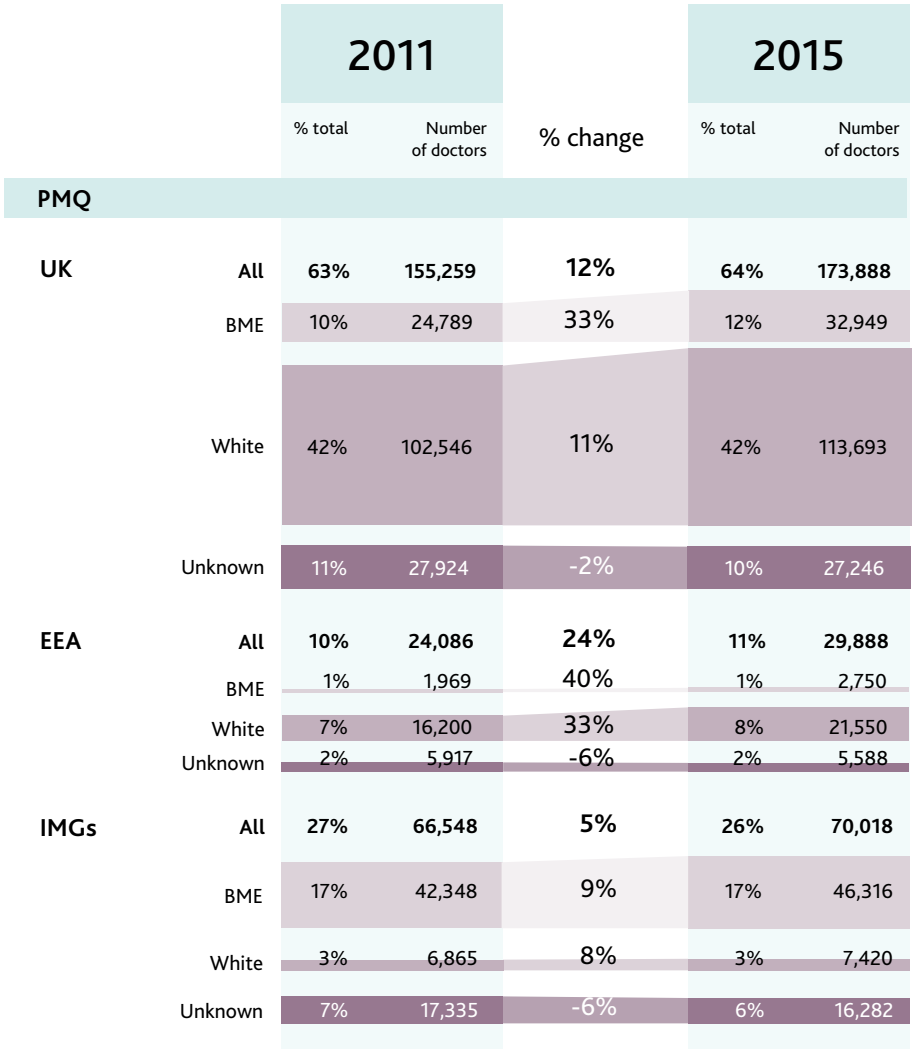
The number of doctors coming from Oceania, which includes Australia, has reduced by well over a third between 2011 and 2015, as has North America, though the actual numbers are much smaller. Although parts of the Middle East have experienced troubles with war and political unrest, the number of doctors coming to the UK from that region has reduced by 18%.

At this point, it is unclear what impact the decision by the UK to leave the European Union will have on the flows of doctors into and out of the country. The factors affecting movement and many and diverse, including the state of the economies in home states, immigration rules, opportunities in the UK and willingness or ability to sit more stringent language checks set by the GMC.

## Impact on the make-up of the register

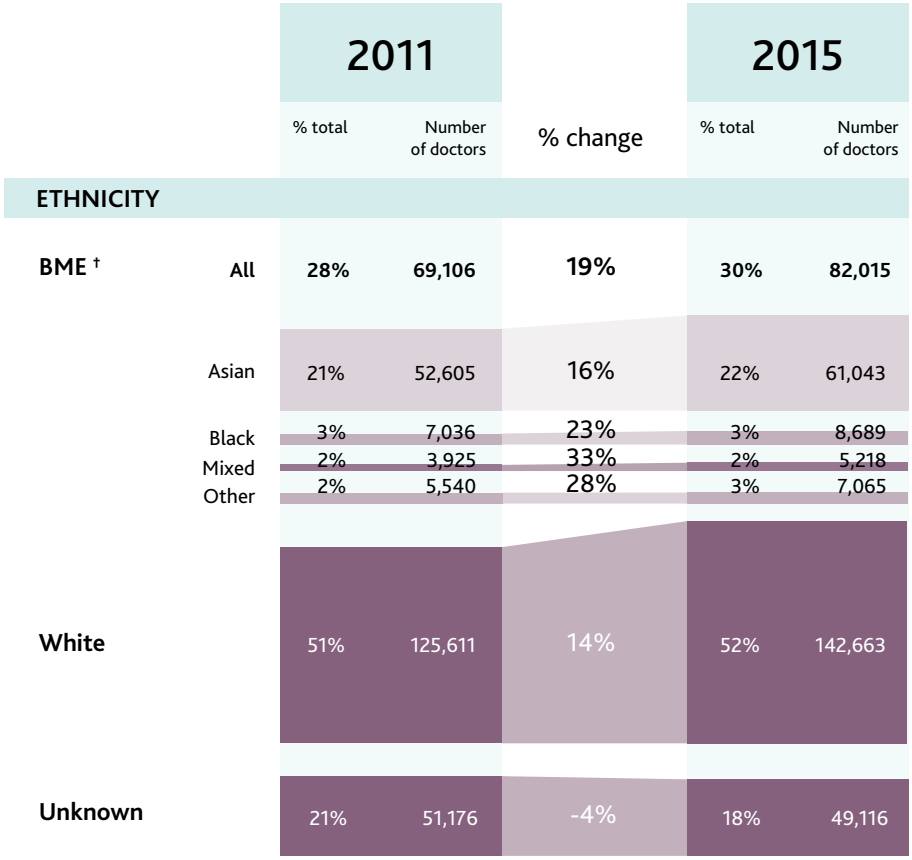
The net effect of the recent trends in migration of doctors on the make-up of the register, in terms of where doctors graduated is shown in figure 10. This migration also affects the ethnic mix of the register, which is shown in figure 11.

**Figure 11: Changes in the primary medical qualification characteristics of doctors on the UK medical register between 2011 and 2015***




* Data are for all registered doctors, including those who do not have a licence to practise.
PMQ = primary medical qualification.

**Figure 12: Changes in the ethnic make-up of doctors on the UK medical register between 2011 and 2015***




* Data are for all registered doctors, including those who do not have a licence to practise.

† BME (black and minority ethnic) includes Asian, black, other ethnic groups and mixed ethnic groups.

# The number of doctors in some specialties is growing faster than in others

In addition to being on the medical register, doctors who have gained their Certificate of Completion of Training (CCT) as a general practitioner (GP) or a specialist can apply to join the GP Register or the Specialist Register. We refer to licensed doctors on these two registers as 'GPs' and 'specialists', respectively.

We refer to licensed doctors who are not on the GP or Specialist Register as 'doctors on neither register'. This group includes doctors in roles that do not need GP or specialist qualifications.

Doctors who are training to be specialists or GPs (doctors in training) are excluded from the analysis in the rest of this chapter and are considered separately in chapter 2.

## Doctors on the Specialist Register are growing faster than those on the GP Register

The number of licensed and non-licensed doctors on the Specialist Register has grown by 21% between 2011 and 2015 to 84,511. The GP Register has not grown as much; by 8% to 64,879 (figure 13). However, these data do not show whether these doctors are working full time or part time once they join the workforce.

A similar pattern is seen when considering licensed doctors only (figure 14). The number of specialist grew by almost 8% between 2011 and 2015, while the equivalent rise in GPs was 2%. The number of doctors who are on neither register and not in training has fallen by 4% in the period between 2012 and 2015.*

* Data for doctors on neither register who are not in training is not available for 2011.

**Figure 13:** Number of doctors on the medical register, including non-licensed doctors 2011–15

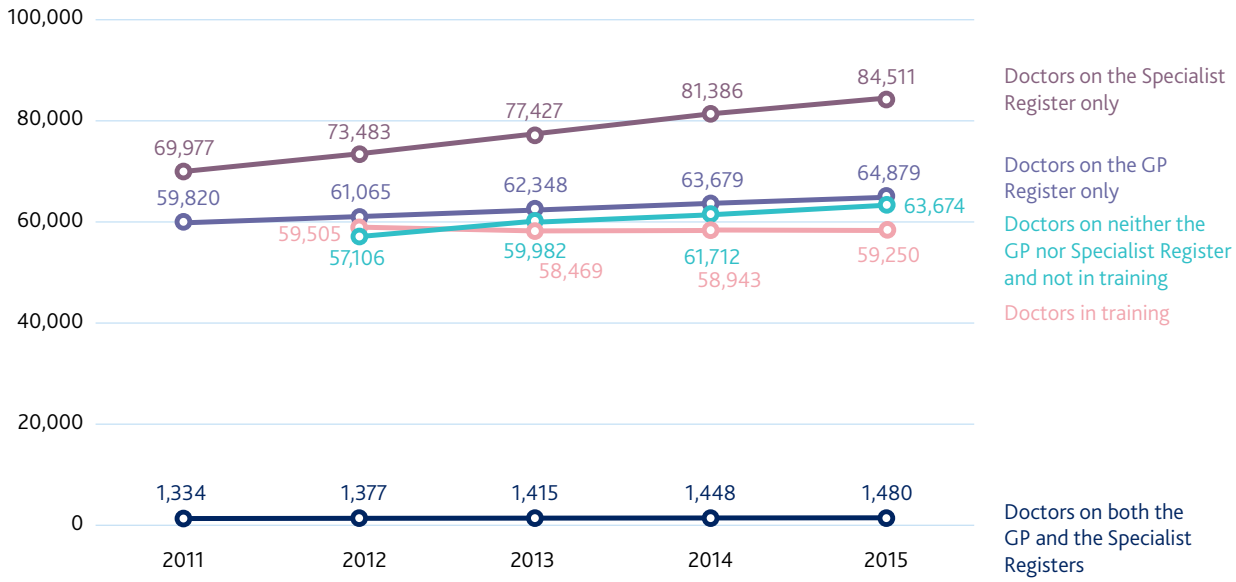



**Figure 14:** The change in the number of licensed doctors by register 2011–15

| | 2011 | | % change | 2015 | |
|---|---|---|---|---|---|
| | % total | Number of doctors | | % total | Number of doctors |
| **TOTAL** | **100%** | **232,761** | **1%** | **100%** | **234,740** |
| **GPs** | 25% | 58,042 | 2% | 25% | 59,068 |
| **SPECIALISTS** | 29% | 66,798 | 8% | 31% | 72,024 |
| **DOCTORS ON NEITHER REGISTER*** | 46% | 106,647 | -4% | 44% | 102,397 |

* Figure includes all licensed doctors on neither register, including both those in training and those not in training.

## Certain specialties are growing much faster than others

Emergency medicine – one of the specialties with the most service pressures, and one of the smallest – has grown by 22%, with 1,971 licensed doctors in 2015. It also has the youngest age profile, with only 27% of doctors aged 50 years and over.

By contrast, public health has shrunk by 15% and occupational medicine by 11%. Pathology has also contracted by 4% to 2,970, and half of all its specialists are aged 50 years and over – the highest percentage of any specialty.

Psychiatry appears to have remained virtually unchanged, but the year-on-year data show that the specialty increased from 8,059 in 2011 to 8,320 in 2013, and then decreased to 8,064 in 2015. This may reflect the recruitment drive by the Royal College of Psychiatrists.[55]

**Figure 15: The change in the number of licensed doctors on the Specialist Register by specialty group 2011–15***

| | 2011 Number of doctors | % change | 2015 Number of doctors |
|---|---|---|---|
| **SPECIALISTS** | 66,798 | 8% | 72,024 |
| **Medicine** | 16,249 | 15% | 18,642 |
| **Surgery** | 12,183 | 7% | 13,066 |
| **Anaesthetics and intensive care medicine** | 9,240 | 6% | 9,832 |
| **Psychiatry** | 8,059 | 0% | 8,064 |
| **Radiology** | 5,133 | 7% | 5,488 |
| **Paediatrics** | 4,736 | 13% | 5,366 |
| **Obstetrics and gynaecology** | 3,533 | 7% | 3,788 |
| **Pathology** | 3,109 | -4% | 2,970 |
| **Ophthalmology** | 1,987 | 11% | 2,200 |
| **Emergency medicine** | 1,616 | 22% | 1,971 |
| **Public health** | 1,343 | -15% | 1,137 |
| **Occupational medicine** | 706 | -11% | 625 |
| **Other specialty or multiple specialty groups** | 178 | -7% | 166 |

* Figure includes all licensed doctors on neither register, including both those in training and those not in training.

# Gender and age of licensed doctors

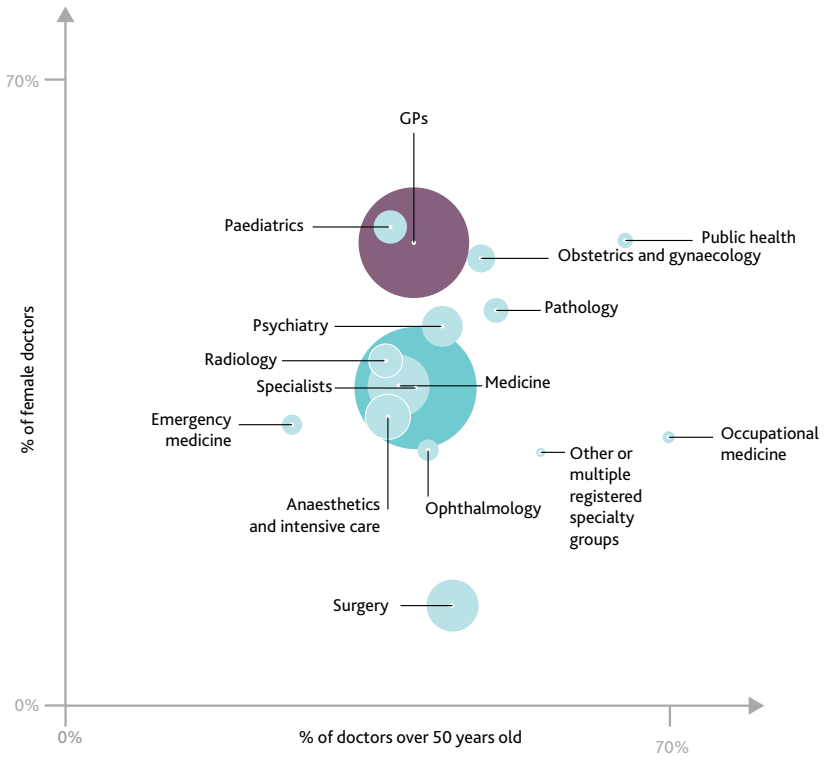
## Two specialties and GPs now have more than 50% female doctors

In last year's edition of this report, we showed that in 2014 the number of female GPs had overtaken the number of male GPs for the first time. In 2015, the proportion of female GPs reached 52% - an increase from 47% in 2011.

Overall, the proportion of specialists (excluding GPs) who are female has increased between 2011 and 2015, from 30% in 2011 to 34% in 2015. In obstetrics and gynaecology, the proportion has risen from 42% to 51%, and in paediatrics it has risen from 49% to 52%. As with GPs, the gender mix in these specialties is close to that in society in general.

But certain specialties remain male dominated. Surgery continues to have the lowest proportion of female doctors (12%, up from 9%), followed by ophthalmology (28%, up from 25%). However, these specialties have seen large increases in the number of female doctors, though from a low base (40% and 27% increases, respectively). The increasing proportion of female doctors in these specialties is likely to increase.

**Figure 16: Age and gender of licensed doctors in 2015**



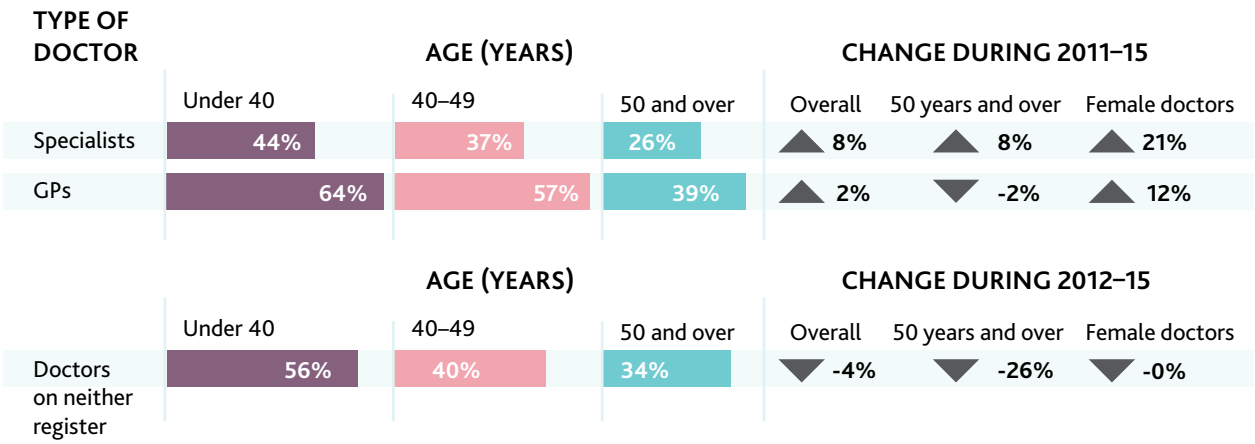
## Growth in the proportion of female licensed doctors is slowing

Younger female doctors are more likely to be joining the profession. 57% of doctors in training in 2015 were female. Older doctors are more likely to leave the medical register through retirement, and these doctors are more likely to be male. This historic trend means that there has been an increase in the proportion of female doctors, as female doctors who join the profession get older and the number of older male doctors decreases as they are gradually replaced.

On both the Specialist and GP Registers, the growth in female doctors with a licence to practise is highest among doctors aged 50 years and over. The number of female specialists aged 50 years and over has increased by 25% between 2011 and 2015, compared with just 3% for male specialists.

For GPs, the number of men aged 50 years and over has actually gone down by 11%, but the number of women in the same age group has increased by 17%. This is in part explained by older GPs, who are predominantly male, retiring. It may also be because GPs who are retired and no longer practise have given up their licence.

**Figure 17: Proportion of female licensed doctors in 2015 and change during 2011–15**



## In some specialties, older women are increasingly present

The specialties that have the highest proportion of older doctors have growing numbers of women.

Pathology, overall, has decreased in size by 4% between 2011 and 2015, but the number of male pathologists has decreased by 12% and the number of women has increased by 6%.

Obstetrics and gynaecology shows the same pattern, with a decrease of 9% in men and an increase of 29% in women. In those aged 50 years and over, men have not increased at all between 2011 and 2015, but women have increased by 41%.

The number of specialists in emergency medicine has increased by 22% overall between 2011 and 2015, but the number of female specialists aged 50 years and over has increased by 75%. Despite this, female doctors overall still make up only 32% of this specialty.

This trend – a relative increase in older female doctors – may be because older male specialist doctors are retiring or giving up their licence to practise.

## Certain specialties are getting older

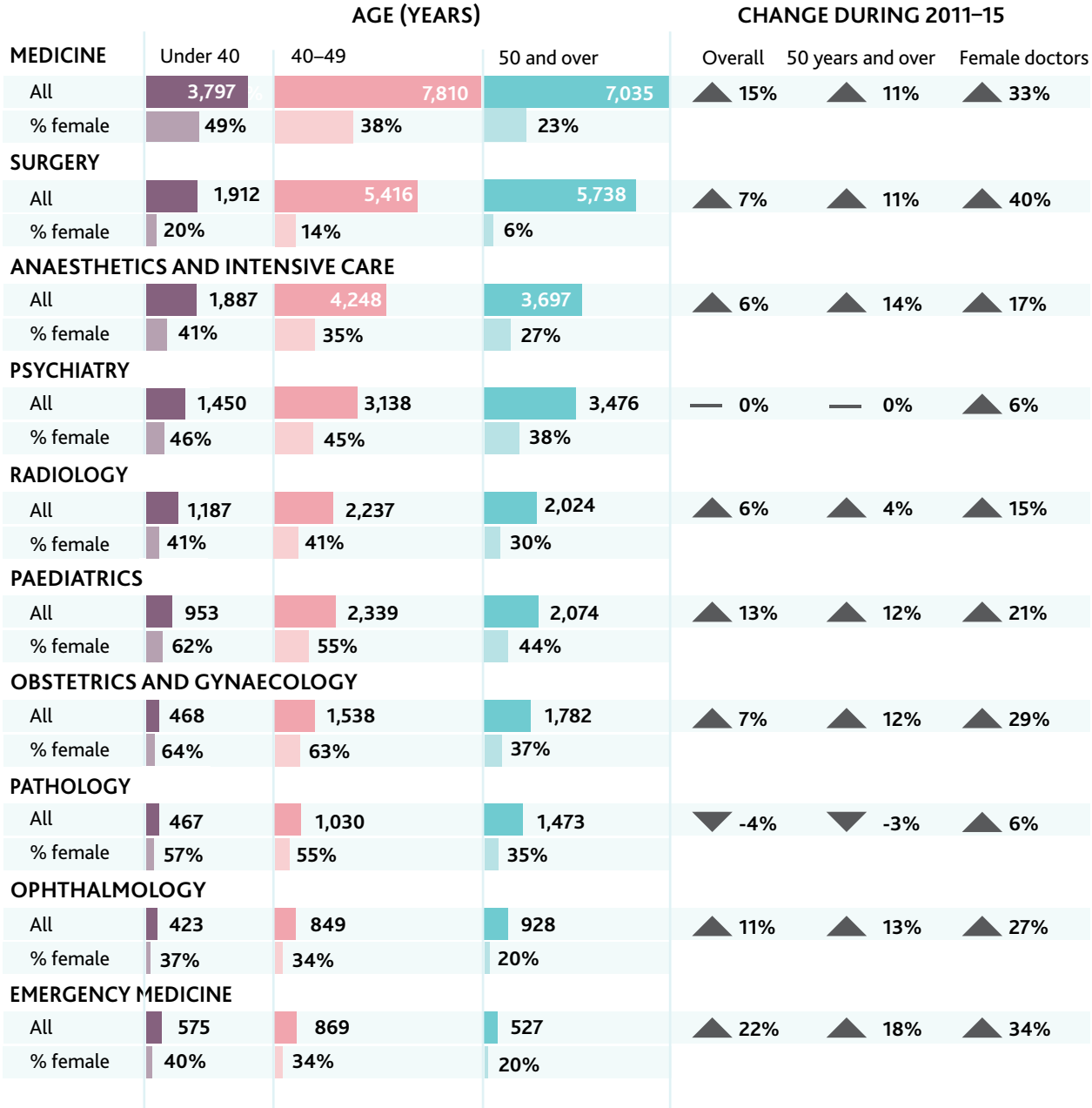
41% of specialists and 39% of GPs are aged 50 years and over. As mentioned above, pathology is the specialty with the highest percentage of specialists aged 50 years and over (50%). Other specialties with high proportions of older doctors include obstetrics and gynaecology (47%) and surgery (44%).

Anaesthetics and intensive care medicine is becoming an older specialty, with 38% of doctors aged 50 years and over compared with 35% in 2011.

By contrast, emergency medicine has the youngest age profile, and has become younger since 2011. Only 27% of doctors were aged 50 years and over in 2015, compared with 28% in 2011.

The trend for some specialties to have an older workforce is not necessarily negative and may reflect people living and working longer. It does not automatically follow that an ageing workforce means an increased risk of doctors retiring. But in some specialties it does appear that, as the number of doctors in the specialty declines, the remaining doctors tend to be older.

**Figure 18:** Gender and age of licensed doctors for the ten largest specialty groups in 2015 and change during 2011–15



# Ethnicity and place of medical qualification of licensed doctors

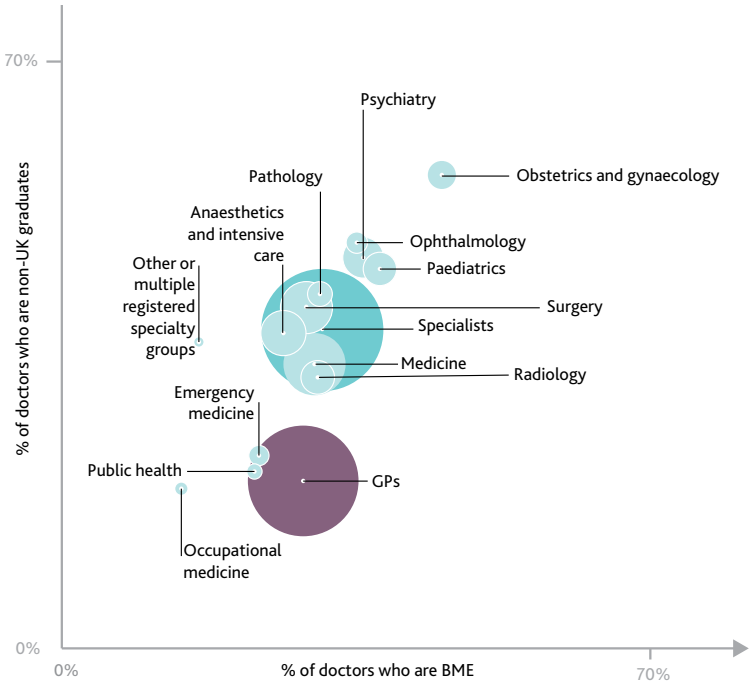
## GPs and specialists who are UK graduates are ethnically diverse and becoming more so

The 2015 data show, that among GPs and specialists who are UK graduates, a higher proportion describe themselves as BME (18% and 16%, respectively, figure 19) than in the UK population overall (13%).[56]

While the profession is already ethnically diverse, it is becoming more so. Between 2011 and 2015, the number of GPs who are BME increased by 18%, compared with an overall increase in GPs of only 2%. Similarly, the proportion of specialists who are BME has increased by 22%, compared with an overall increase of only 8%.

Some part of the increased proportion of doctors identifying as BME is explained by a reducing number of doctors who do not give the GMC their ethnicity. However, the number of licensed doctors with unknown ethnicity declined by 20% during 2011–15 (from 45,128 to 36,198). Although a proportion of these doctors will now be identified as BME or white, the numbers are too small to account for the overall trend.

**Figure 19: Place of primary medical qualification and ethnicity of licensed doctors in 2015**



## Specialties are increasingly relying on non-UK graduates

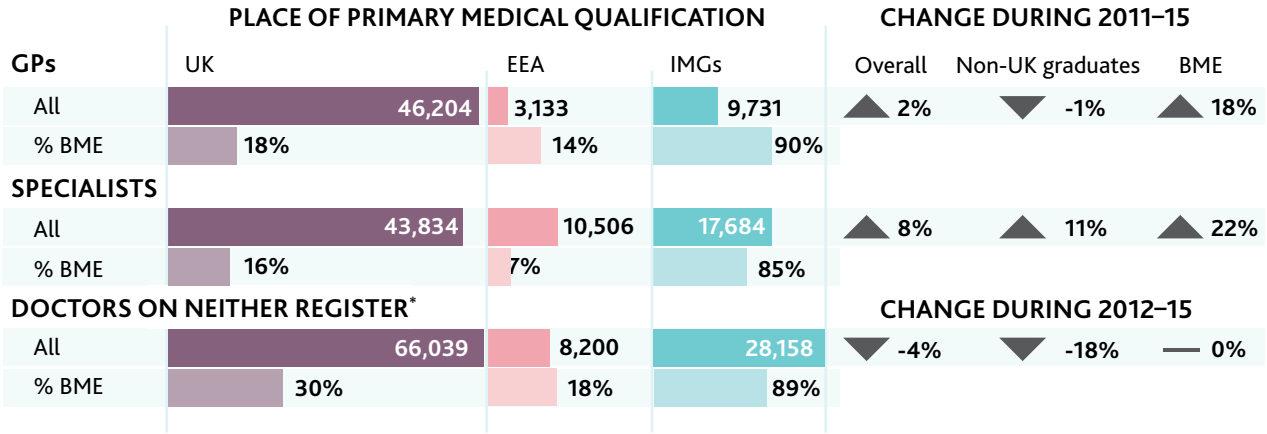
Several specialties are made up of a greater proportion of non-UK graduates and BME doctors (figure 20), with obstetrics and gynaecology, paediatrics, ophthalmology and psychiatry the highest.

Only two specialties – radiology and anaesthetics and intensive care – have decreased their reliance on non-UK graduates during this five-year period. All other specialties have seen an increase in the proportion of non-UK PMQ doctors (figure 20).

The proportion of obstetricians and gynaecologists who are non-UK graduates has risen from 52% to 56%, making it the most reliant. Perhaps unsurprisingly, it has the highest proportion of BME doctors – 46% up from 41%. In this specialty, 90% of IMGs describe themselves as BME, compared with 16% of UK graduates and 9% of EEA graduates.

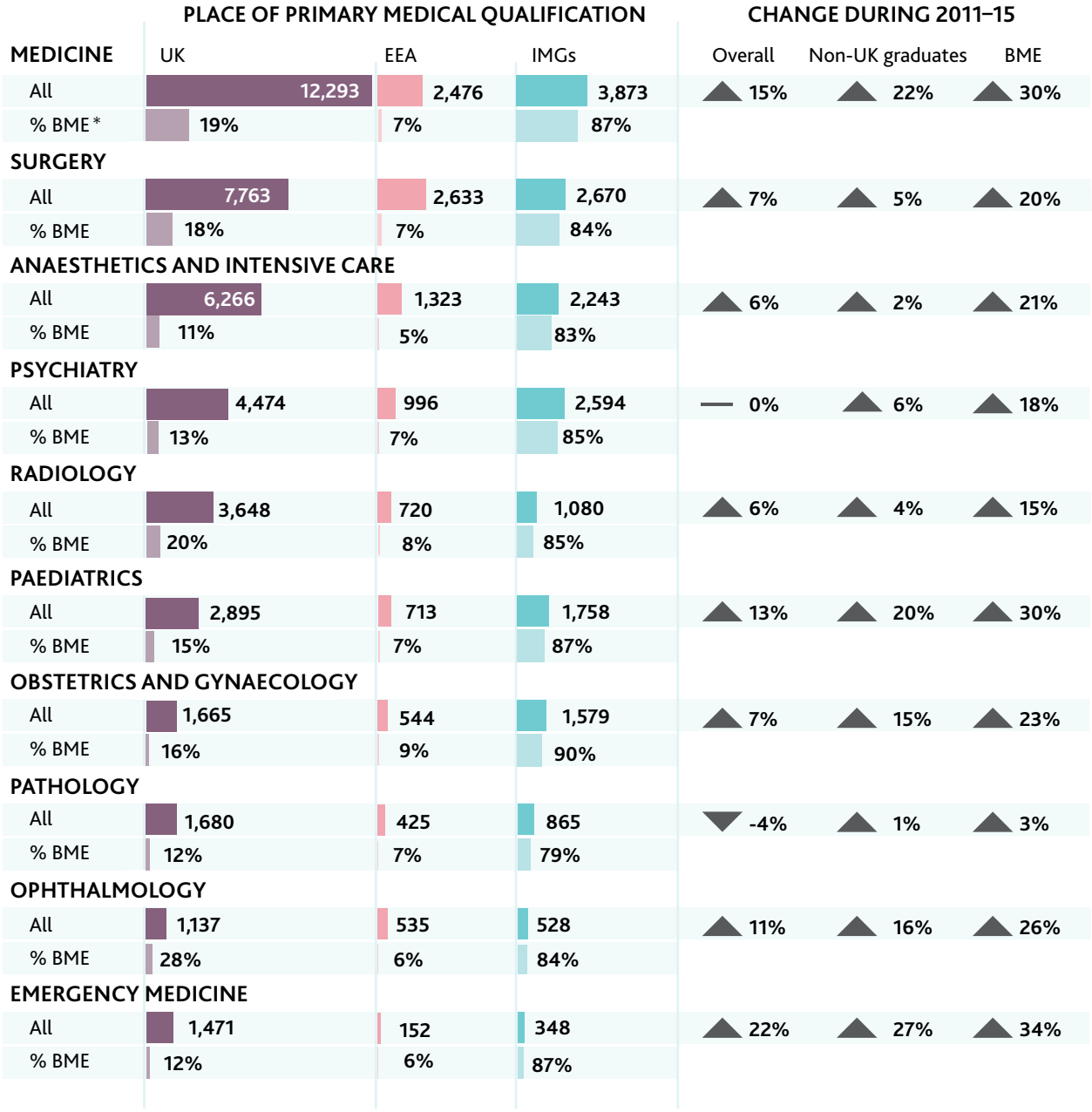
Other specialties are growing specifically because of the growing reliance on EEA graduates and IMGs. For example, the number of medicine specialists has increased by 15% overall, but the number of non-UK graduates has increased by 22%. Similarly, paediatrics grew by 13% overall but has 20% more non-UK graduates, and psychiatry did not grow overall but has 6% more non-UK graduates.

**Figure 20: Place of primary medical qualification and ethnicity of licensed doctors by register type in 2015 and change during 2011–15**




* Change during 2012–15. Includes doctors on neither register not in training and doctors on neither register in training. The percentage of BME doctors is calculated as a percentage of only doctors who disclosed their ethnicity. Doctors whose ethnicity is 'not recorded' are not included in these percentages, but are included in the total figures.

**Figure 21: Place of primary medical qualification and ethnicity of licensed doctors for the ten largest specialty groups in 2015 and change during 2011–15**




* The percentage of BME doctors is calculated as a percentage of only doctors who disclosed their ethnicity.
Doctors whose ethnicity is 'not recorded' are not included in these percentages, but are included in the total figures.

# Revalidation of licensed doctors

## Revalidation requires all fully licensed doctors to demonstrate they are keeping their skills and knowledge up to date.

It is an ongoing process: all licensed doctors are expected to undergo an appraisal every year based on our core guidance for doctors, *Good medical practice*, and to collect supporting information about their practice and reflect on this with their appraiser.

Every five years, a doctor's Responsible Officer recommends to the GMC that:

- the doctor should be revalidated
- the doctor's revalidation date should be deferred while the doctor gathers further evidence or while local processes involving the doctor are resolved
- the doctor has failed to engage.

Deferring the decision to revalidate a doctor 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.

Most licensed doctors have a connection with one organisation that provides them with an appraisal and helps them with revalidation.

This organisation is called the doctor's designated body.* It is usually their primary employer or body responsible for their performance.

In 2015, 69,071 doctors (30% of all eligible licensed doctors†) had a recommendation made by their Responsible Officer that was approved by the GMC. While each of these could have a number of outcomes through the year (eg deferred and then later in the year revalidated), the final outcomes for these doctors at the end of 2015 were:

- 57,599 were revalidated – of these, 47,757 had revalidation as their first recommendation in the current revalidation cycle, and 9,842 were revalidated after having a previous recommendation‡
- 11,263 were deferred to allow them to gather further evidence or resolve local processes§
- 209 failed to engage with appraisal or with local systems or processes that support revalidation.

6,555 doctors (67%) who were revalidated after a previous recommendation had their revalidation deferred in 2014, and were then revalidated in 2015. It is reasonable to assume that a similar proportion of the doctors whose outcomes in 2015 were deferrals will also be revalidated in 2016.

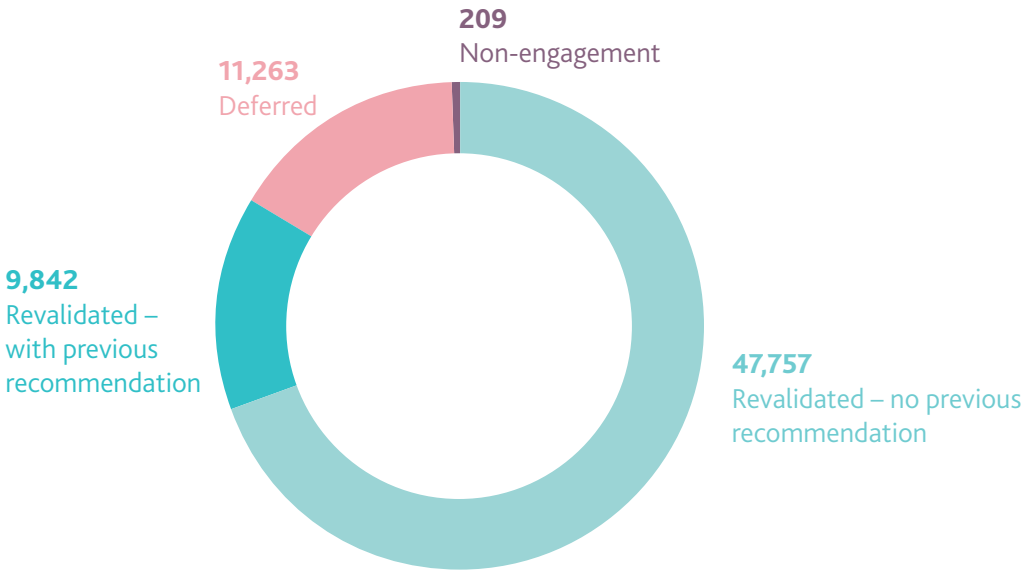
* This can be a deanery or local education and training board (LETB), some faculties, a health board, an independent provider, a locum agency, NHS England, a membership organisation, a secondary healthcare trust or a suitable person.

† Not all doctors are required to revalidate – all doctors who are fully registered with a licence to practise are required to revalidate except those registered under sections 18, 18A or 27A of the *Medical Act 1983*.

‡ A previous recommendation is a deferral approved by the GMC or a non-engagement recommendation in the same revalidation cycle.

§ A very small number (seven) of these doctors may have had a non-engagement recommendation in the same revalidation cycle, but their latest recommendation was for deferral.

**Figure 22: Outcomes of revalidation processes in 2015**

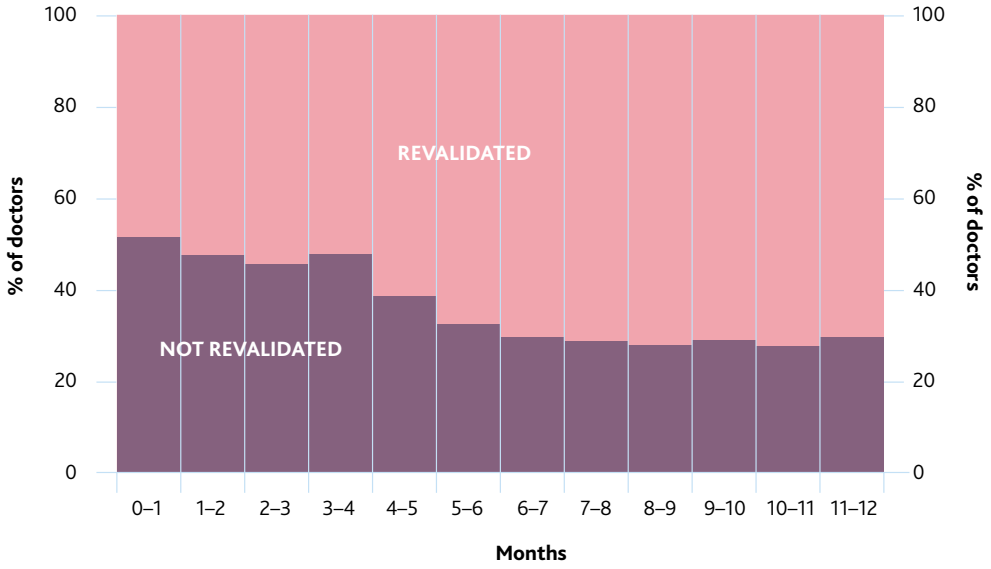



## Certain groups are more likely to have their revalidation deferred

During 2015, certain cohorts of doctors were more likely to have their revalidation deferred, such as doctors recently connected to a designated body. 44% of recommendations in the first month of connection were to revalidate, compared with 70% of recommendations at six to seven months after connecting.

This is likely to be because Responsible Officers need time to consider information from previous Responsible Officers, as well as the findings from their own appraisal with the doctors, before making a recommendation.

Figure 23: **Revalidation decisions in 2015 by length of time a doctor had been connected to their designated body***




## Locum doctors have a lower rate of revalidation

Doctors connected to a locum agency for revalidation were less likely to be revalidated (67% in 2015) than those connected to most other organisations (80–93%, figure 24). Due to the nature of their work, locum doctors working in secondary care have a tendency to change their designated body connection more often than doctors connected to other types of designated body.[57]

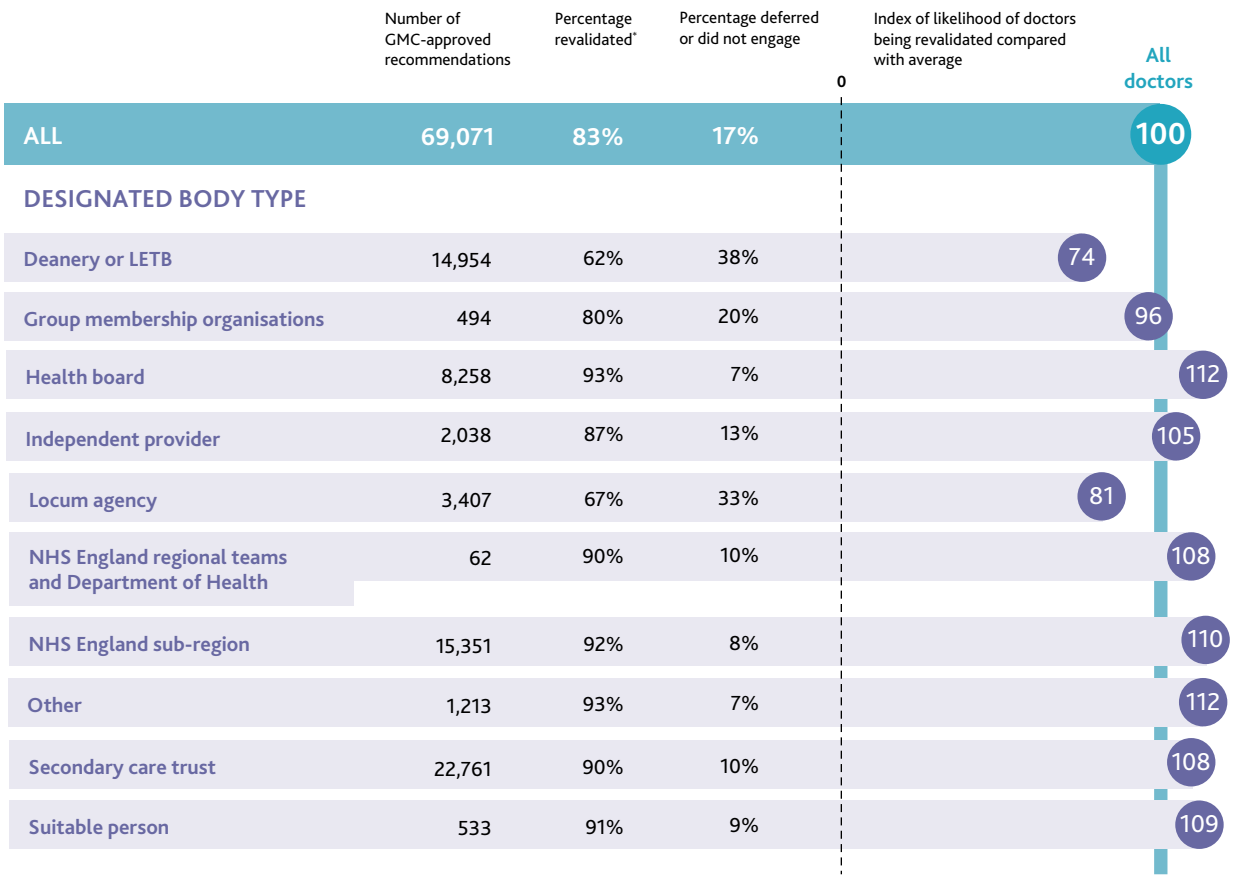
Where doctors work for more than one locum agency, they may connect to their designated body very close to their revalidation date as they need to connect to the agency they do the most work with over each year. This is in line with the earlier observation that doctors are more likely to be deferred if they have recently connected to a designated body.

It is also possible that some of the deferrals reflect the difficulty locum doctors have in gathering evidence about their practice.[57] In some cases it may reflect concerns by their Responsible Officer about aspects of their practice. The inclusion of locum doctors in a managed system is one of the clear advantages of the revalidation arrangements, as they have long been identified as an area of medicine where oversight and governance have been lacking, and where there have been concerns about the quality of care being provided in some cases.[57] However, it is also an area where more work is required and it is one of the aspects of revalidation that will be considered in the review by Sir Keith Pearson on revalidation.†

* 4,377 doctors had more than one type of recommendation approved by the GMC in 2015 – they appear against more than one recommendation type in this figure.

† The GMC has commissioned Sir Keith Pearson, Chair of the GMC's Revalidation Advisory Board to lead a review of revalidation. The review will draw on evidence of the operation and impact of revalidation since it was launched in December 2012 and look forward to how it can be improved. The aim will be to produce recommendations for changes during 2017.

**Figure 24: Revalidation outcomes in 2015 by type of designated body connection**




## Doctors connected to a deanery or LETB are more likely to have their revalidation deferred

The type of designated body that a doctor is connected to affects the likelihood of a recommendation to defer revalidation. In particular, doctors connected to a deanery or LETB have a lower revalidation rate (62% in 2015) than doctors connected to other types of designated body. Most of these doctors are in training.

This is largely just a technical issue. Doctors in training have to revalidate either every five years (if their training programme lasts longer than five years) or on the date they are given their CCT.** This means that Responsible Officers often have to defer the revalidation date for doctors in training to bring it in line with their CCT date.

* Includes doctors revalidated after a previous recommendation, and doctors revalidated without a previous recommendation.

** A CCT confirms that a doctor has completed an approved training programme in the UK and is eligible for entry onto the GP Register or the Specialist Register.

## Doctors' age affects the likelihood of deferring revalidation

In 2015, doctors aged 20–39 years old and those over 70 years old were more likely to have their revalidation deferred than other age groups (figure 25).

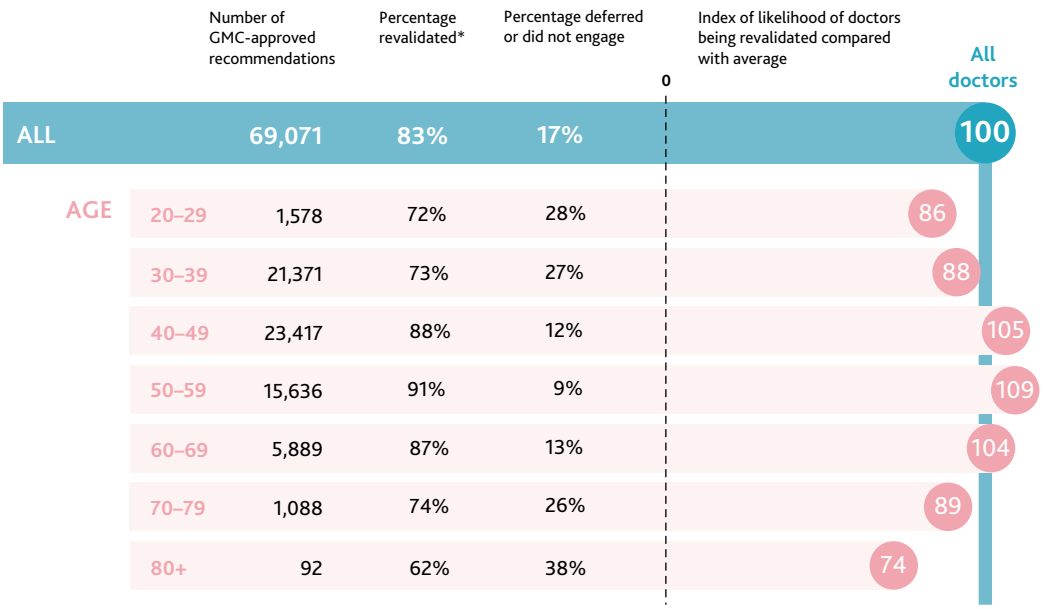
Doctors aged 39 years old and under are more likely to be in training and therefore are more likely to have their revalidation date deferred to bring it in line with their expected CCT award date.

Doctors aged 70 years old and over are less likely to have revalidated. These doctors also show a higher rate of deferral than other age groups, which was largely because of insufficient evidence. 92 doctors over 80 years old had a revalidation decision, of whom 57 were revalidated, 28 were deferred and seven did not engage with the process.

## Male doctors are slightly more likely to be revalidated than female doctors

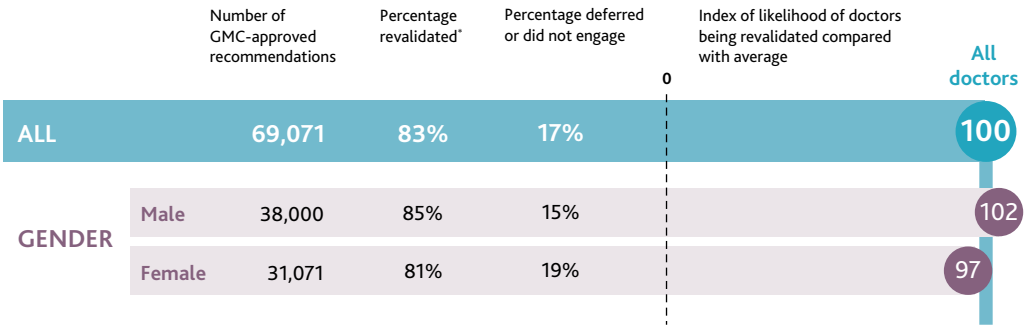
Men were more likely to be revalidated than women, but the differences are minimal (85% vs 81%, figure 26). This may be because more doctors in training are female and so may have their revalidation date deferred to bring it line with their expected CCT award date.

**Figure 25: Revalidation outcomes in 2015 for doctors by age**




* Includes doctors revalidated after a previous recommendation, and doctors revalidated without a previous recommendation.

Figure 26: **Revalidation outcomes in 2015 for doctors by gender**




## The small number of doctors failing to engage in revalidation has increased

The number of doctors who have had their licence withdrawn because their Responsible Officer submitted a non-engagement recommendation about them has increased. In 2014, we withdrew a licence from 24 doctors following a non-engagement recommendation from their doctor. In 2015, this number increased to 62.

In many cases these doctors were working overseas or were retired. However, to protect patients, the fact that these doctors could not or would not demonstrate that they could meet the standards required has meant that they are no longer allowed to practise in the UK.

* Includes doctors revalidated after a previous recommendation, and doctors revalidated without a previous recommendation.

## Key findings from our data on doctors working in the UK

- The number of licensed doctors is still growing, even though thousands have given up their licence to practise since 2011.
- The trend for increasing numbers of EEA graduates to come to the UK, particularly from southern Europe, has reversed – there are now fewer doctors on the register from almost all world regions.
- More than 50% of GPs and specialists in obstetrics and gynaecology and in paediatrics are now female. The proportion of doctors who are female continues to increase across the medical profession as a whole, but is not yet representative of the overall UK population.
- The medical profession is more ethnically diverse than the UK generally and is becoming more so.
- Obstetrics and gynaecology relies heavily on non-UK graduates – 56% are EEA graduates or IMGs. Other specialties, such as medicine and psychiatry, have increased or maintained the proportions of non-UK graduates.

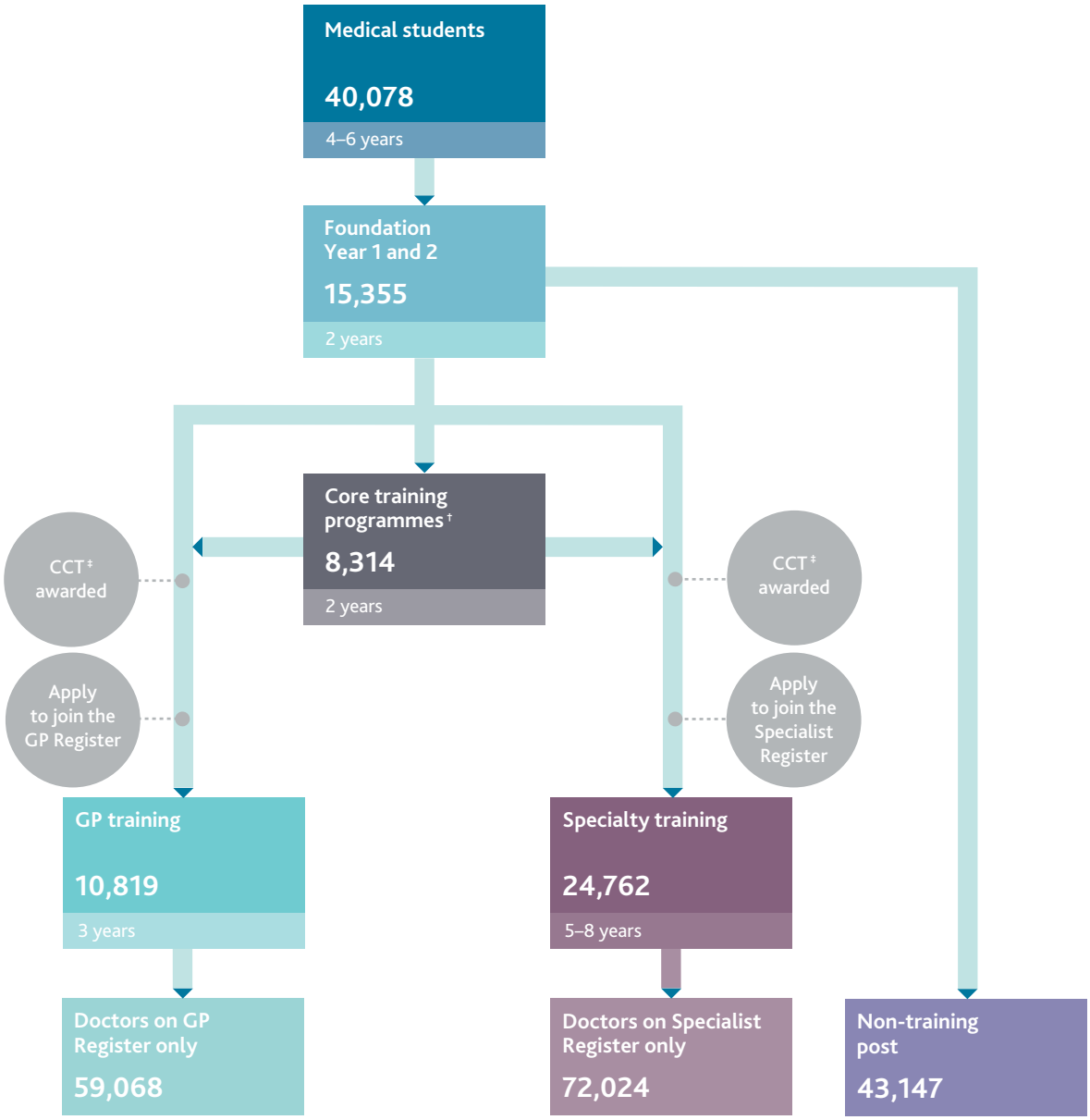
# Chapter two:

# Our data on medical students and doctors in training in the UK

After graduating from medical school, doctors start two years of foundation training. In their first year of foundation training, doctors are provisionally registered with a licence to practise and can apply for full registration when they complete that first year.

After two years of foundation training, doctors who continue to train in the UK can go into GP training, or specialty training, or they can practise as a doctor without further training (figure 27). At each stage – foundation training, core training, GP training or specialty training – graduates of non-UK medical schools also join the training programmes.

**Figure 27:** Medical students and doctors at each stage of medical education in 2015*




* Not all medical students and doctors in training will continue to the next stage – they may pause their training, leave the profession or change their training programme. Doctors who are on both the Specialist and the GP Registers are not counted in this figure.

† Core training programmes include acute care common stem, broad based training, and other core training programmes.

‡ Certificates of Completion of Training (CCT).

# Who are the UK's medical students?

There were 40,078 medical students at UK universities in 2015 – down 3% since 2012 (figure 28).* This decrease is partly due to a planned reduction in medical school intakes in England from 2013.[58]

The number of medical students at UK universities who are European (excluding British) has stayed relatively low at 3% of all medical students, but has increased by 161 students (15%) between 2012 and 2015.† The figure for students identifying themselves as British has also fallen by 3% (down 1,278) while the figure for students who are non-European has reduced by 6% (down 227).

Medical students are increasingly diverse – the number of black and minority ethnic (BME)‡ students increased by 8% from 12,883 in 2012 to 13,946 in 2015. There was a 7% decrease in white students, though ethnicity was not recorded for 1,731 students in 2015. Of those recorded, white students made up 61% of the total. This compares with the population, which was 86% white at the last census.[59]

* In this chapter we examine data from 2012-15 as data on the training programme was unavailable to the GMC prior to 2012.

† These data are from annual reports that medical schools send to the GMC. You can find further information in the reference tables about medical students at www.gmc-uk.org/somep2016.

‡ BME includes Asian, black, mixed ethnic groups and other non-white ethnic groups.

**Figure 28: Changes in the demographic characteristics of medical students during 2012–15**

| | 2012 | | % change | 2015 | |
|---|---|---|---|---|---|
| | % total | Number of medical students | | % total | Number of medical students |
| **TOTAL** | **100%** | **41,422** | **-3%** | **100%** | **40,078** |
| Nationality | | | | | |
| British | 89% | 36,836 | -3% | 89% | 35,558 |
| European (excluding British) | 3% | 1,064 | 15% | 3% | 1,225 |
| Non-European | 9% | 3,522 | -6% | 8% | 3,295 |
| Gender | | | | | |
| Female | 55% | 22,691 | -3% | 55% | 21,949 |
| Male | 45% | 18,731 | -3% | 45% | 18,129 |
| Ethnicity | | | | | |
| BME | 31% | 12,883 | 8% | 35% | 13,946 |
| White | 63% | 26,125 | -7% | 61% | 24,401 |
| Not recorded | 6% | 2,414 | -28% | 4% | 1,731 |

# Who are the UK's doctors in training?

Overall, the number of doctors in training was similar in 2012 and in 2015. This number has not kept up with the 2.2% growth in the UK population from 63.7 million to 65.1 million,[60] but overall the number of professionally qualified clinical staff working in NHS trusts has increased faster – with a 3.7% increase from 2012 to 2015.[61]

## The increase in female doctors may be starting to slow

In previous editions of this report, we have described the increase in the proportion of doctors who are female. In 2015, female doctors made up 57% of all doctors in training, up from 56% in 2012. Female doctors also made up 59% of all doctors in training under 30 years old.

This increase may be starting to slow – there has been a reduction of 3% in the number of female doctors under 30 years old compared with a 9% increase in male doctors in the same age group (figure 29).

Despite a slight reduction in younger female doctors in training, there has still been an overall increase in the number of female doctors in training. The number of older female doctors in training continues to increase – those aged 30 years and over increased by 7% – which is consistent with the tranche of younger female doctors ageing and older female doctors re-entering training, or starting training after moving here from overseas. This pattern is also consistent with female doctors, who are more likely to be training part time, training for longer into their thirties.

**Figure 29: Changes in the demographic characteristics of doctors in training during 2012–15**

| | | 2012 | | % change | 2015 | |
|---|---|---|---|---|---|---|
| | | % total | Number of doctors in training | | % total | Number of doctors in training |
| **TOTAL** | | **100%** | **59,505** | **0%** | **100%** | **59,250** |
| Gender | | | | | | |
| | Female | 56% | 33,454 | 2% | 57% | 34,015 |
| | Male | 44% | 26,051 | -3% | 43% | 25,235 |
| Age* and gender | | | | | | |
| **<30 years** | **All** | **48%** | **28,568** | **2%** | **49%** | **29,063** |
| | Female | 30% | 17,591 | -3% | 29% | 17,053 |
| | Male | 18% | 10,977 | 9% | 20% | 12,010 |
| **30+ years** | **All** | **52%** | **30,937** | **-2%** | **51%** | **30,187** |
| | Female | 27% | 15,863 | 7% | 29% | 16,962 |
| | Male | 25% | 15,074 | -12% | 22% | 13,225 |

* In 2012 and 2015 only 0.3% of doctors in training were aged 50 years and over, so these are not reported on separately here.

## Fewer doctors in training are Asian

The largest change in the proportion of doctors by ethnicity is in the unknown group, which shrunk by 27% from 7,422 to 5,339 doctors (figure 30). This drop is a result of more doctors choosing to disclose their ethnicity to the GMC, and by doctors who had not disclosed their ethnicity leaving the medical register.

Despite more doctors disclosing their ethnicity, there are also fewer doctors in training who are Asian – this is the only ethnic group to have reduced in number between 2012 and 2015. This reduction mirrors the overall reduction in the number of Asian doctors on the UK medical register (chapter 1, figure 10). In last year's report[21] we showed that the reduction in non-UK doctors was due to a mixture of primarily younger doctors leaving the UK to practise abroad, and older doctors retiring or moving overseas.

**Figure 30: Changes in the ethnicity of doctors in training during 2012–15**

| | | 2012 | | | 2015 | |
|---|---|---|---|---|---|---|
| | | % total | Number of doctors in training | % change | % total | Number of doctors in training |
| **TOTAL** | | **100%** | **59,505** | **0%** | **100%** | **59,250** |
| Ethnicity | | | | | | |
| **BME** | **All** | **34%** | **19,971** | **-2%** | **33%** | **19,506** |
| | Asian | 25% | 14,984 | -7% | 24% | 13,924 |
| | Black | 3% | 1,816 | 7% | 3% | 1,935 |
| | Mixed | 3% | 1,588 | 19% | 3% | 1,890 |
| | Other | 3% | 1,583 | 11% | 3% | 1,757 |
| **WHITE** | | 54% | 32,112 | 7% | 58% | 34,345 |
| **UNKNOWN** | | 12% | 7,422 | -27% | 9% | 5,399 |

## The number of UK graduates in training is increasing and they are ethnically diverse

The number of UK graduates* in training has grown by 6% (up by nearly 3,000), while the number of graduates from the rest of the European Economic Area (EEA)† is virtually unchanged (up by just 22) and the number of international medical graduates (IMGs)‡ has decreased significantly by a third (down by more than 3,000), over the four years (figure 31).

In short, while the number of doctors in training has not changed, the make-up of these doctors is changing. They are increasingly likely to have gained their primary medical qualification in the UK and, of those, 24% are BME.

By comparison, at the time of the last census in 2011, BME people represented only 14% of the population in England and Wales,[62] 4% in Scotland [63] and 2% in Northern Ireland.[64] Doctors in training are much more ethnically diverse than the UK population.

## There are fewer IMGs in training

The number of IMGs in training reduced by 32% (from 9,535 to 6,467 doctors) between 2012 and 2015. This mirrors the overall trend reported in chapter 1 (figure 9) of there being fewer IMGs on the UK medical register.

* UK graduates are doctors who gained their primary medical qualification in the UK. This group includes doctors who are UK nationals and those who are nationals of other countries and went to medical school in the UK.

† 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 31: Changes in the ethnicity and place of primary medical qualification of doctors in training during 2012–15**

| | | 2012 | | % change | 2015 | |
|---|---|---|---|---|---|---|
| | | % total | Number of doctors in training | | % total | Number of doctors in training |
| **TOTAL** | | **100%** | **59,505** | **0%** | **100%** | **59,250** |
| Place of medical qualification and ethnicity | | | | | | |
| **UK** | **All** | **80%** | **47,837** | **6%** | **85%** | **50,628** |
| | BME | 22% | 12,900 | 12% | 24% | 14,429 |
| | White | 50% | 30,039 | 8% | 55% | 32,386 |
| | Unknown | 8% | 4,898 | -22% | 6% | 3,813 |
| **EEA** | **All** | **4%** | **2,133** | **1%** | **4%** | **2,155** |
| | BME | 1% | 378 | 16% | 1% | 438 |
| | White | 2% | 1,440 | 6% | 3% | 1,533 |
| | Unknown | 1% | 315 | -42% | 0% | 184 |
| **IMGs** | **All** | **16%** | **9,535** | **-32%** | **11%** | **6,467** |
| | BME | 11% | 6,693 | -31% | 8% | 4,639 |
| | White | 1% | 633 | -33% | 1% | 426 |
| | Unknown | 4% | 2,209 | -37% | 2% | 1,402 |

## Which doctors are in which training programmes?

Both the obstetrics and gynaecology and the psychiatry training programmes have seen a 10% drop in the number of doctors in training.

General practice remains the largest training programme beyond foundation training, and the number of GP doctors in training has increased by 2% during 2012–15.

**Figure 32: Changes in the number of doctors in each training programme during 2012–15**

| | 2012 | | 2015 |
|---|---|---|---|
| | Number of doctors | % change | Number of doctors |
| **TOTAL** | **59,505** | **0%** | **59,250** |
| Foundation | 15,049 | 2% | 15,355 |
| Core elements of specialty training | 8,513 | -2% | 8,314 |
| Specialty | | | |
| Anaesthetics | 2,899 | -8% | 2,667 |
| Emergency medicine | 565 | * | 1,110 |
| General practice | 10,617 | 2% | 10,819 |
| Medicine | 6,814 | -6% | 6,418 |
| Obstetrics and gynaecology | 2,291 | -10% | 2,067 |
| Ophthalmology | 673 | -2% | 658 |
| Paediatrics and child health | 3,644 | 1% | 3,666 |
| Pathology | 760 | -4% | 726 |
| Psychiatry | 1,356 | -10% | 1,223 |
| Public health | 217 | 2% | 221 |
| Radiology | 1,533 | 3% | 1,584 |
| Surgery | 4,394 | -5% | 4,155 |
| Other | 180 | 48% | 267 |

* The structure of the emergency medicine training programme has changed and like-for-like % change is not possible to show, see box 1.

## BOX 1: Emergency medicine

Growth in emergency medicine has been largely due to the changes in the training programme in 2013. It is therefore not possible to compare the latest figures with the previous ones. Before the changes, doctors completed three years in the acute care common stem (ACCS) training programme, followed by three years' training in emergency medicine. Now the programme is delivered as a single six-year programme as well as allowing doctors to progress from ACCS into emergency medicine.

The first three years – ST1 to ST3 – therefore show an increase from 0 doctors in training to 421.

However, by looking only at those doctors in the past four years of their programme, we are able to see that the number of emergency medicine trainees has increased in those years by 22%. It also shows that the increase is not entirely explained by the restructuring of the training programme as the past four years are unaffected by the change to a six-year programme.

**Figure 33: Doctors training in emergency medicine by stage of training, 2012–15**

| Year/stage of training | 2012 | % change | 2015 | |
|---|---|---|---|---|
| CT1* | 2 | | 2 | |
| ST1 | 0 | | 152 | Doctors training in ST1 to ST3 in 2015 are training in the six-year run through the emergency medicine programme. |
| ST2 | 0 | | 144 | |
| ST3 | 0 | | 125 | |
| ST4 | 169 | 22% | 287 | The increase seen here is 22%, and shows the increase in emergency medicine is not entirely explained by the change to a single six-year training programme. |
| ST5 | 155 | | 197 | |
| ST6 | 238 | | 204 | |
| ST7 | 1 | | 1 | |
| **Total** | **565** | | **1,110** | |

Before 2014 doctors trained in the ACCS programme before moving on to emergency medicine in ST4.

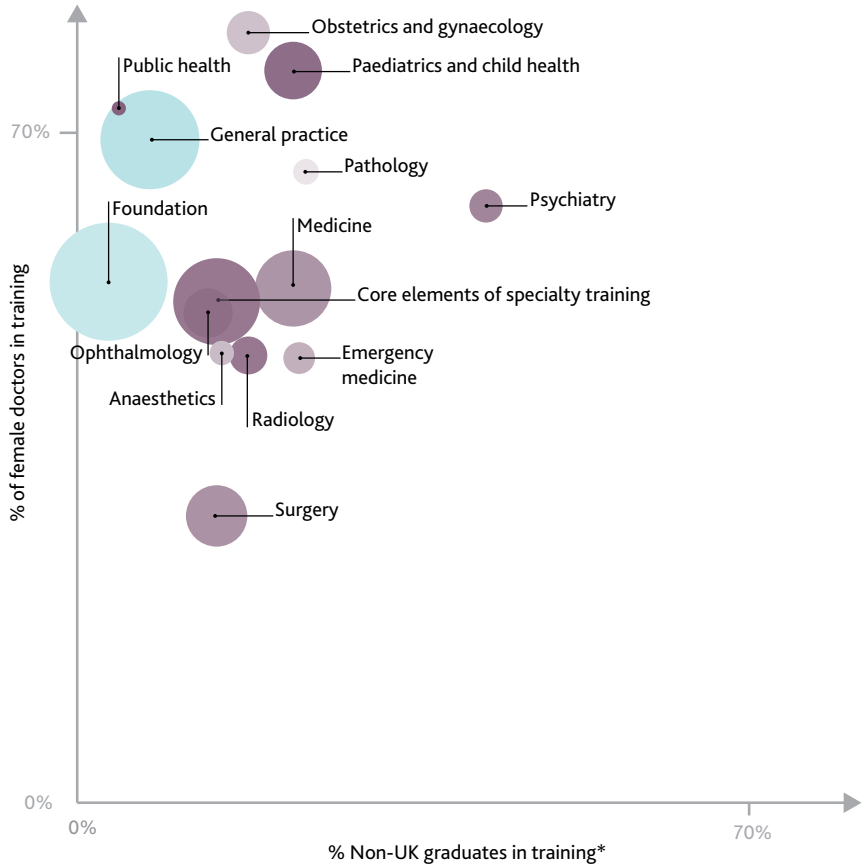
* Two CT1s in 2012 had a primary programme specialty reported as emergency medicine, but also had a secondary specialty of ACCS – emergency medicine.

Most doctors in foundation training are UK graduates (96%) and are female (56%; figure 34). The proportion of foundation doctors who are female has dropped marginally from 59% to 56% during 2012–15.

Over a third (41%) of doctors in psychiatry training are non-UK graduates* – the highest proportion of any training programme. The next highest are emergency medicine and pathology, with non-UK graduates representing 23% and 24% of doctors training in those specialties respectively. By contrast, only 7% of doctors training in public health and 13% training in anaesthetics are non-UK graduates.

The training programmes with the highest proportions of female doctors are obstetrics and gynaecology (81%), paediatrics and child health (77%), and public health (71%). The proportion of female doctors training in surgery has increased to 30% from 25% in 2012, but it remains the lowest proportion of female doctors in any training programme.

**Figure 34: Gender and place of primary medical qualification of doctors in training programmes in 2015**




* Non-UK graduates include doctors who gained their primary medical qualification outside of the UK, who are either EEA graduates, or IMGs. These doctors may or may not have non-UK nationalities.

# Chapter three: Complaints about doctors

This chapter sets out the number of complaints received by the GMC in 2015 and how these complaints have been resolved. It also examines trends over the past five years and changes in the source of these complaints.

## Complaints and how they were handled

### An apparent end to a rapid increase in complaints

The number of complaints increased sharply between 2010 and 2012 growing by 51% but since 2012 there has been a marked slowing down in the growth of complaints (figure 35). Indeed in 2015, the number of complaints actually fell to 8,269* – a 7% reduction on 2014.

### How the GMC handled complaints about doctors in 2015

A complaint about a doctor to the GMC can lead to one of three decisions:

- To undertake a full GMC investigation
- To refer the complaint to the doctor's employer to resolve locally
- To close the case immediately.†

Of the complaints received in 2015, 27% were investigated, 6.8% were sent back to employers for further examination and 65.5% were closed (figure 36).‡

* Overall, the GMC received 9,092 enquiries in 2015. Of these, 91% related to a doctor's fitness to practise and became a complaint.
† In September 2014, the GMC reformed the initial triage process; all cases closed without investigation are counted as closed immediately.
‡ A small number of cases (48) were still being triaged on 7 July 2016 when the data was downloaded.

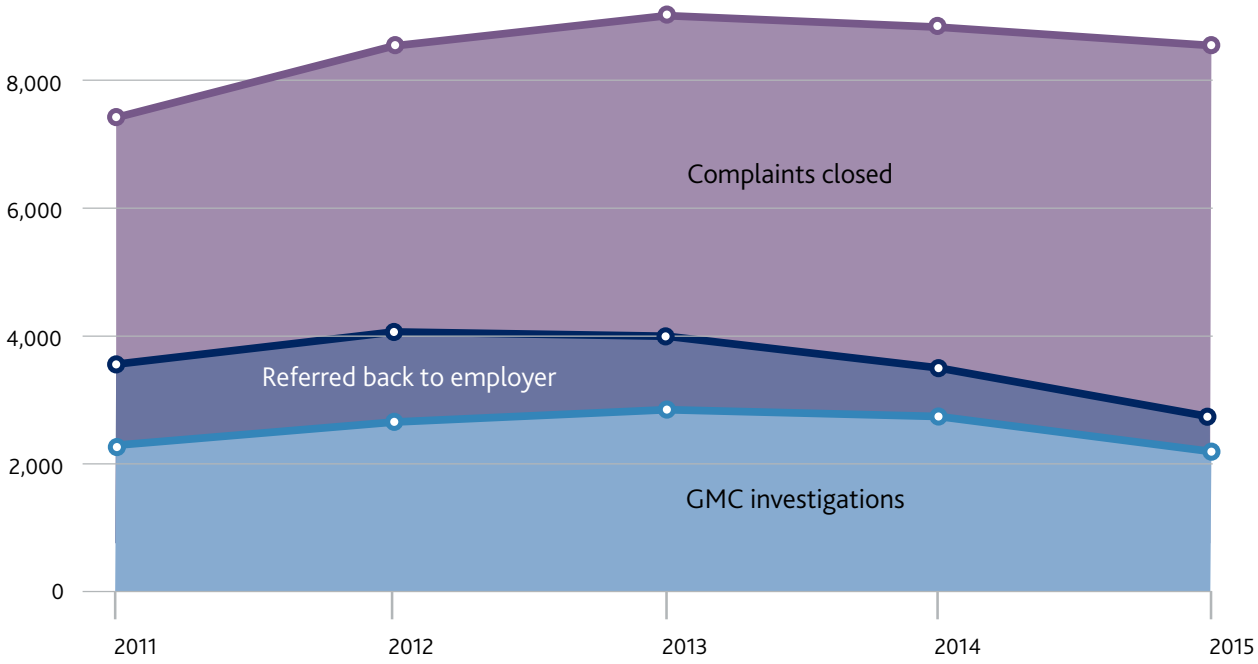
## Fewer complaints made required investigation since 2014

The number of investigations remained broadly steady between 2012 and 2014, but reduced by 18% in 2015. This reflects the fact that the GMC has reformed the initial triage process so staff can more accurately judge which enquiries merit a full investigation.

In 2015, 562 complaints did not merit a full investigation and were referred back to doctors' employers to deal with. This number was 5% lower than a year earlier (591 complaints in 2014) and 62% lower than five years earlier (1,494 complaints in 2011).*

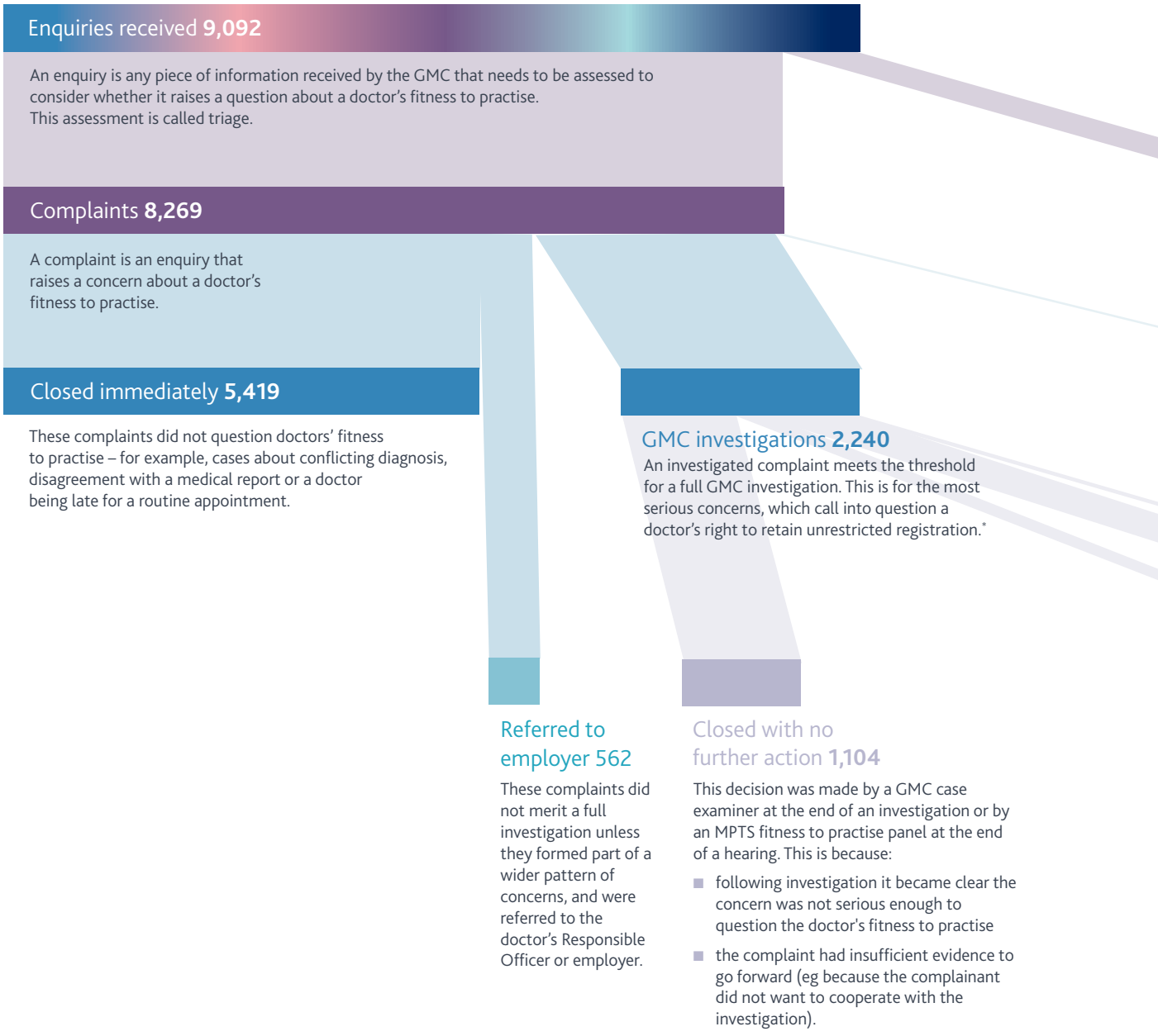
The number of cases closed immediately has increased by 47% during 2011–15.

**Figure 35: Number of complaints and investigations during 2011–15**




* Prior to September 2014, some of the complaints received about doctors that did not meet our threshold for investigation resulted in a 'preliminary investigation'. This no longer happens and complaints of this nature are referred back to the employer to be handled in the first instance by the relevant Responsible Officer.

**Figure 36: How the GMC handled enquiries received about doctors in 2015**



Enquiries not about a doctor's fitness to practise **823**

### Enquiry still open **48**

These are enquiries where no decision has yet been made on whether or not to investigate; this includes where the GMC is waiting for external data.

### Closed with advice **225**

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

### Still being investigated **800**

These complaints were unresolved on 7 July 2016.

### Sanction or warning given **111**

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 **48**

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 **55**

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 **8**

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

* 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 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.

# Where do complaints come from?

The GMC receives complaints from a wide range of sources (figure 37). Of the 8,269 complaints received in 2015, the majority (5,597, 68%) came from the public. While the public remains the largest source, the number peaked in 2013 and declined in the following two years (figure 37).

9% of complaints came from other doctors in 2015. The number from this source is now slowing. The number rose by an average of 11% per year between 2011 and 2014, but by only 1% between 2014 and 2015.

6% of complaints came from employers in 2015. The number from this source rose in 2012, possibly because of the publicity around the importance of raising concerns during the Mid Staffordshire NHS Foundation Trust Inquiry, but has now settled.

A relatively small proportion of complaints came from the police and the GMC itself in 2015, and reduced substantially between 2011 and 2015 (by 31% for police and 55% for GMC complaints). Much of this fall was in the last year, with the number of complaints from police falling by 18% and those from the GMC by 34%. The fall in complaints from the police may be associated with changes to their procedures in 2015, which mean they now legally require a 'pressing social need' to justify sharing information with the GMC.

The percentage of complaints that result in a full GMC investigation varies substantially depending on the source of the complaint. Complaints made by employers were most likely to merit a GMC investigation (80%).

Doctors (not including senior doctors acting as Responsible Officers or employers) referred 752 of their colleagues to the GMC in 2015; 31% of these complaints resulted in an investigation.

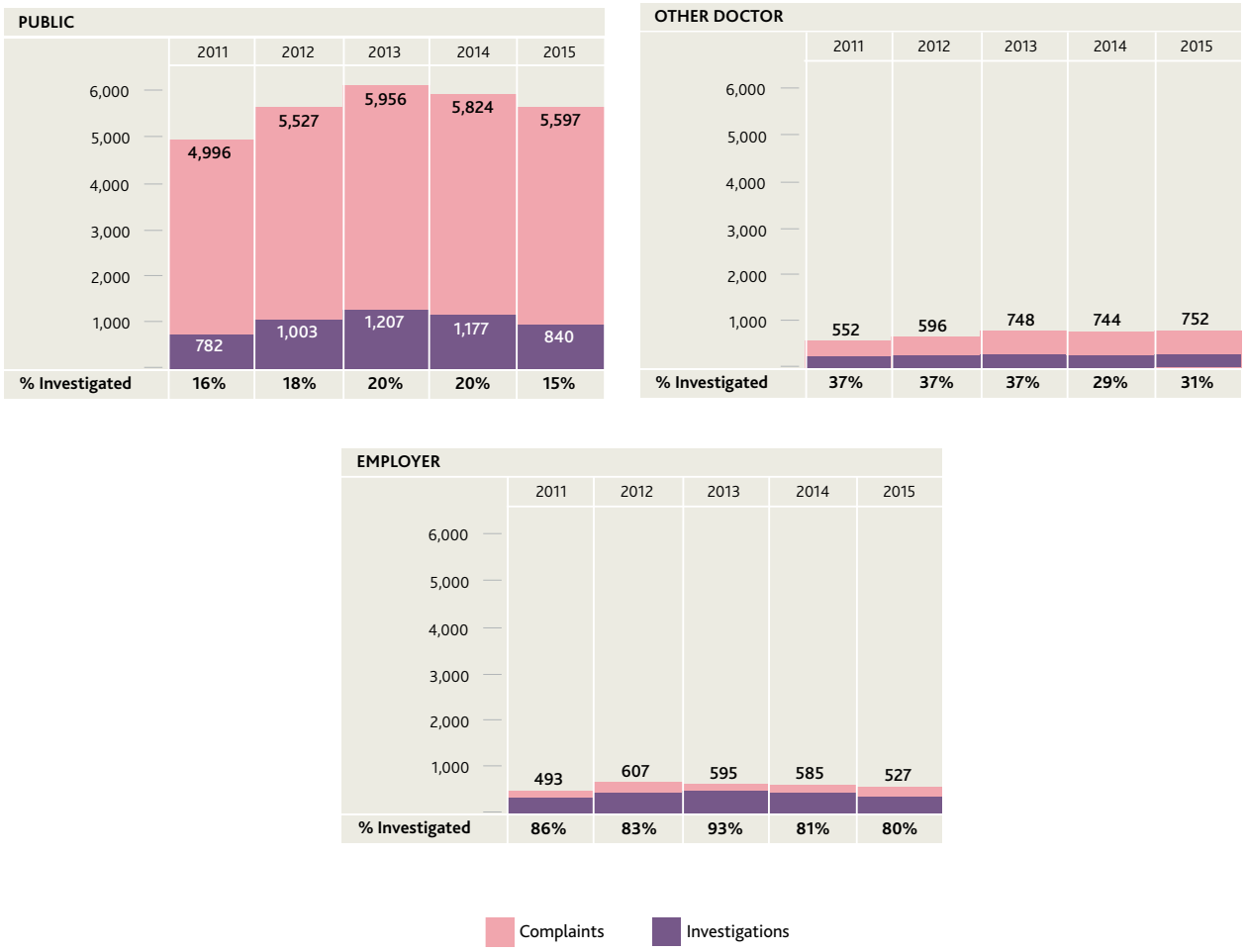
Only 15% of complaints made by the public in 2015 resulted in an investigation. But, because the public made approximately ten times more complaints than employers did, the highest number of investigated complaints came from the public.

## Self-referrals are increasing, but fewer are investigated

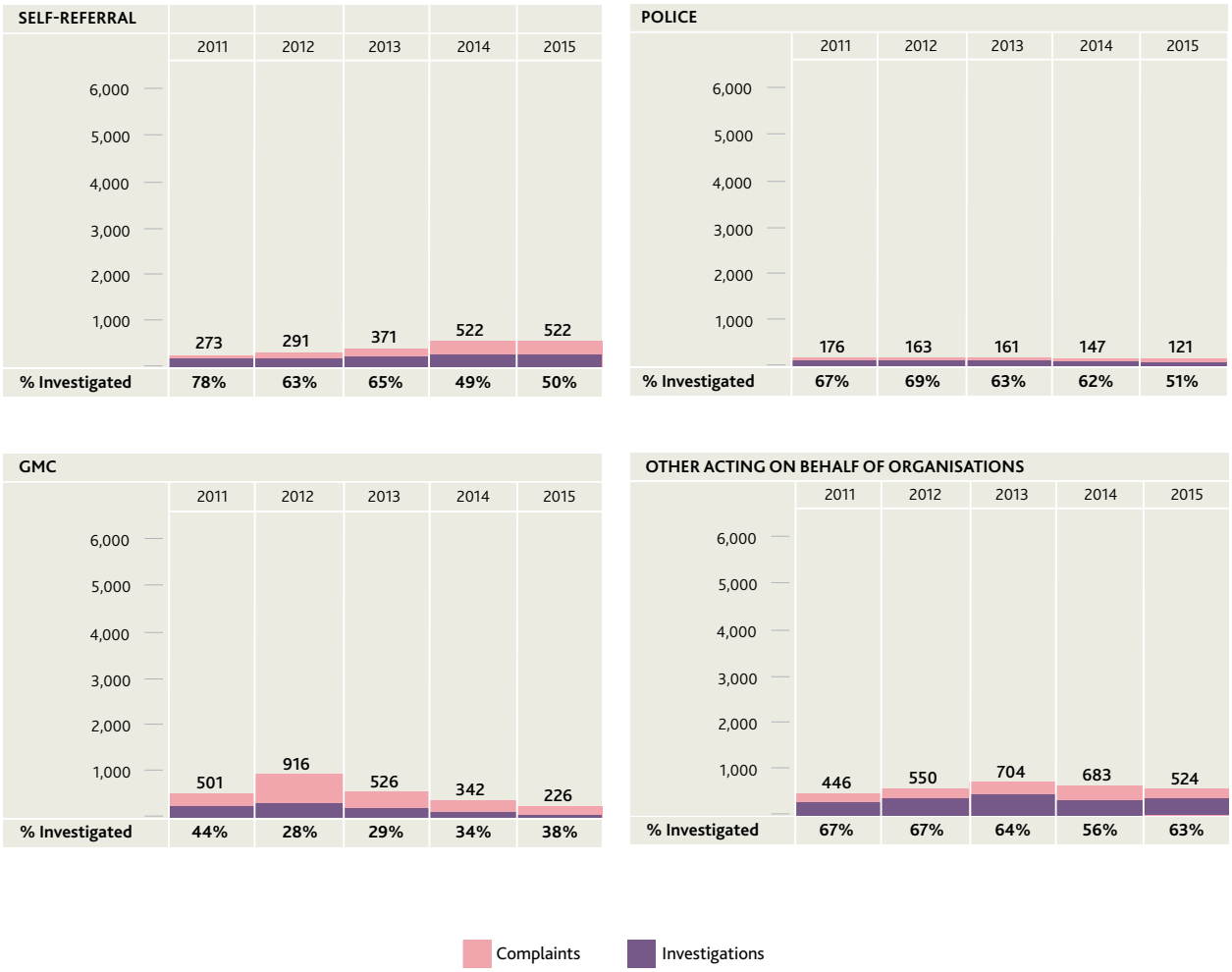
The number of self-referrals – from doctors concerned that they may have breached fitness to practise standards – increased by 91% between 2011 and 2015. Most self-referrals are about health and criminal matters.

There were 522 self-referrals in 2015, a similar number to 2014. Half of the self-referrals in 2015 were investigated, compared with 78% in 2011.

## Figure 37: Number of complaints and investigations from each source in 2011–15 (part 1)



## Figure 37: Number of complaints and investigations from each source in 2011–15 (part 2)



# What were the outcomes of cases concluded in 2015?

This section reports the outcomes of cases that were completed in 2015 and the trends in outcomes between 2011 and 2015.

### A note on data

Data presented here show the number of cases closed in 2015. The year in which a case concludes is often different from the year the complaint was received.[21] This means that the number of cases closed differs from the number of complaints received each year, and is not comparable with the data presented in figure 38.

Following an investigation where the GMC concludes that the allegations meet its threshold,* the doctor will be either offered undertakings that restrict their practice or referred to a tribunal of the Medical Practitioner Tribunal Service. The tribunal has a number of sanctions at its disposal:

- If the doctor cannot continue to practise safely, or it is not appropriate for them to do so, they will be **suspended** or **erased** from the medical register, preventing them from working as a doctor in the UK.
- If the doctor's fitness to practise is impaired, but it is safe for them to continue practising with appropriate support, supervision or re-training, they will be given **conditions** or they may agree to **undertakings**.
- If it is judged that the doctor is fit to practise, but there is evidence that they should reflect on how they meet professional standards, they will be given a **warning**.

In cases where the GMC concludes its threshold has not been met:

- If there is evidence that the doctor should reflect on how they meet professional standards, they will be given a warning.
- All other cases are closed with no further action or, where there has been a low-level issue that does not merit a warning, the case may be closed with advice given to the doctor.

In this section, the data refer to cases closed during the five-year period 2011–15 irrespective of when the complaint was received.

## Between 2011 and 2015 the numbers of doctors suspended and erased both increased, but in proportion to the growing number of complaints

In 2015, 2,808 investigations were concluded, of which:

- 69% were closed with no further action
- 14% were closed with advice given to the doctor
- 5% resulted in warnings

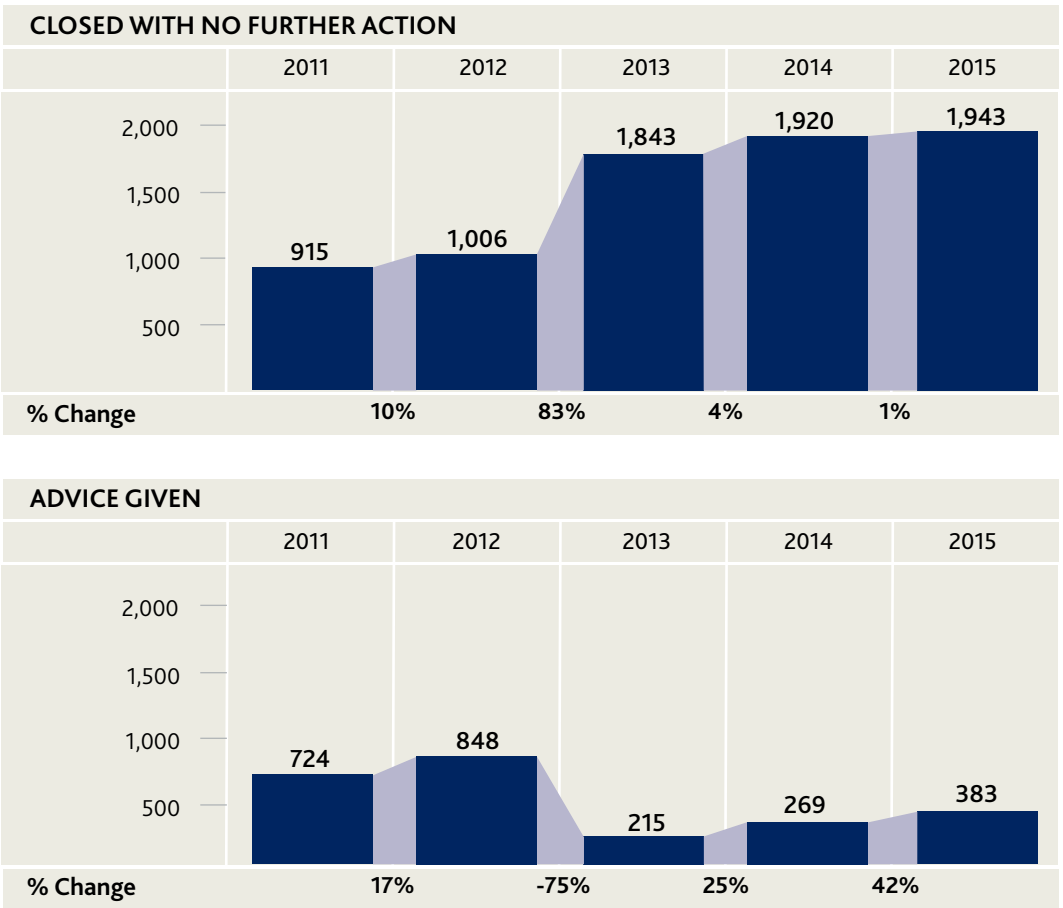
* The complaint calls into question a doctor's right to retain unrestricted registration.

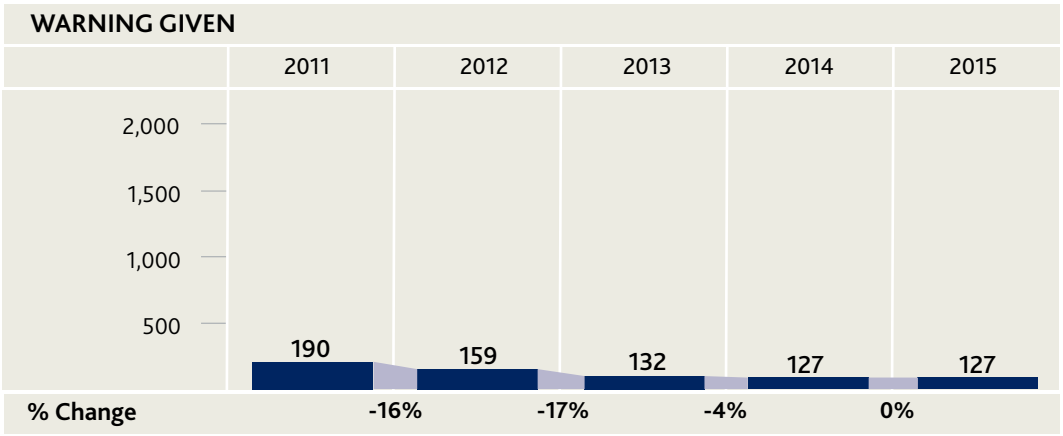
- 6% resulted in conditions or undertakings
- 7% resulted in suspension or erasure.

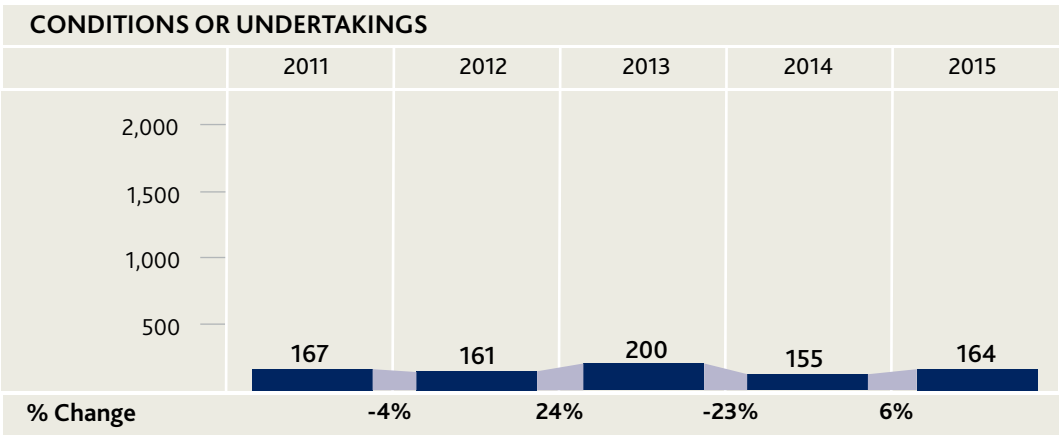
During 2011–15, the number of investigations closed with advice reduced by almost half (47%). This is because the GMC changed its process for issuing advice, which we examined in last year's report. [21] Over the same period, the number of investigations resulting in a warning reduced by a third, while the number resulting in conditions and undertakings has remained constant.

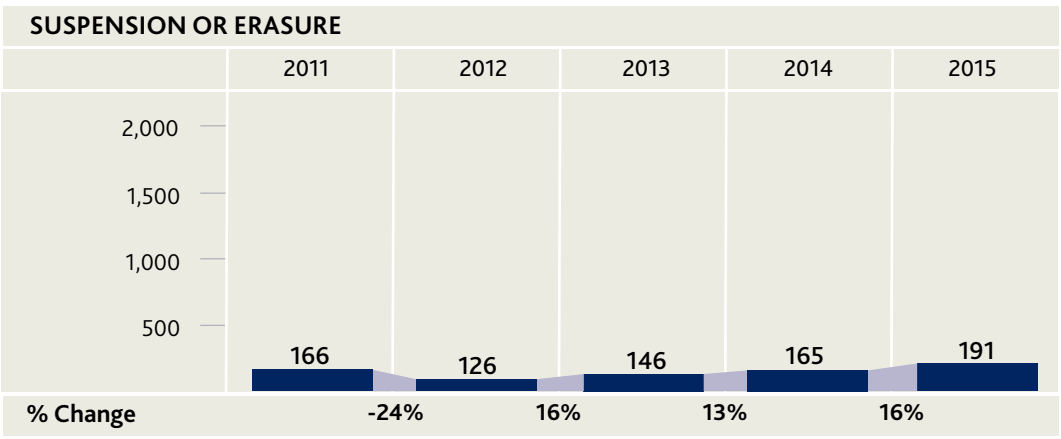
After a sharp fall in the number of doctors being suspended or erased in 2012 there has been a steady increase of about 15% a year to 2015. The increase reflects the overall increase in the number of investigations – the proportion of investigations leading to a suspension or erasure has remained broadly similar.

**Figure 38: Outcomes of investigations closed each year during 2011–15**




WARNING GIVEN
2011
2012
2013
2014
2015
2,000
1,500
1,000
500
190
159
132
127
127
% Change
-16%
-17%
-4%
0%


CONDITIONS OR UNDERTAKINGS
2011
2012
2013
2014
2015
2,000
1,500
1,000
500
167
161
200
155
164
% Change
-4%
24%
-23%
6%


SUSPENSION OR ERASURE
2011
2012
2013
2014
2015
2,000
1,500
1,000
500
166
126
146
165
191
% Change
-24%
16%
13%
16%

# Chapter four:

# Groups of doctors at higher risk of complaints and investigations

In this chapter, we examine the number of doctors being complained about, investigated and receiving a sanction or a warning.

# Introduction

## Only small numbers are complained about

Only a relatively small number of doctors are complained about each year: figure 39 shows that 3% of doctors were the subject of a complaint to the GMC in 2015. GPs were slightly more likely to be complained about, whereas those on neither the GP nor the Specialist Register were less likely. The proportion of specialists complained about was similar to the average proportion of all doctors.

Overall, the number of doctors complained about each year is relatively small for all types of doctors. Furthermore, as noted in chapter 3 only one in three complaints lead to a full GMC investigation and less than one in five investigations lead to a sanction or a warning. Figure 40 shows that the proportion investigated varies between different types of doctors.

**Figure 39: Different types of doctors who were complained about in 2015**

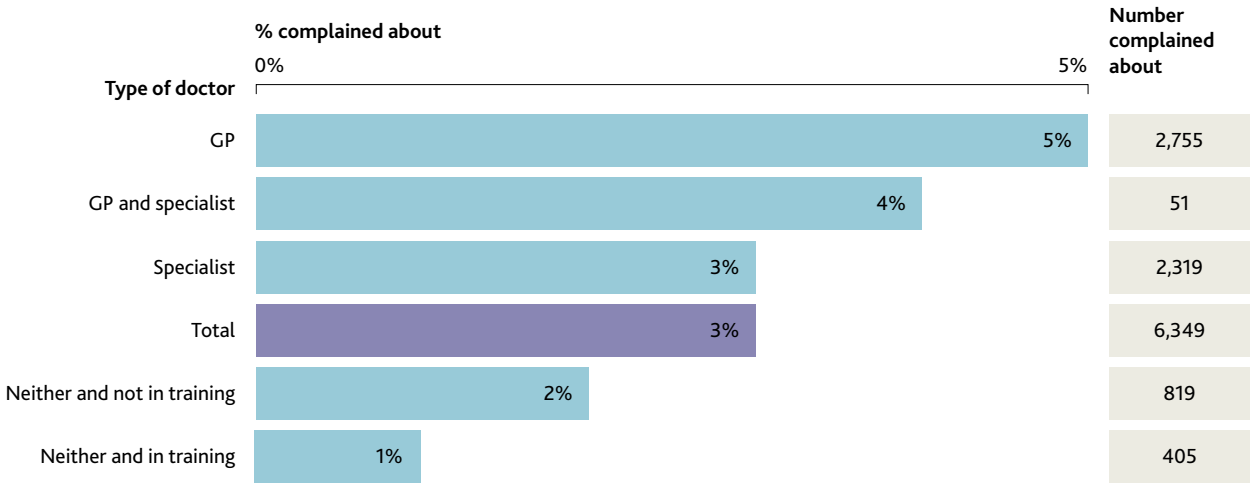
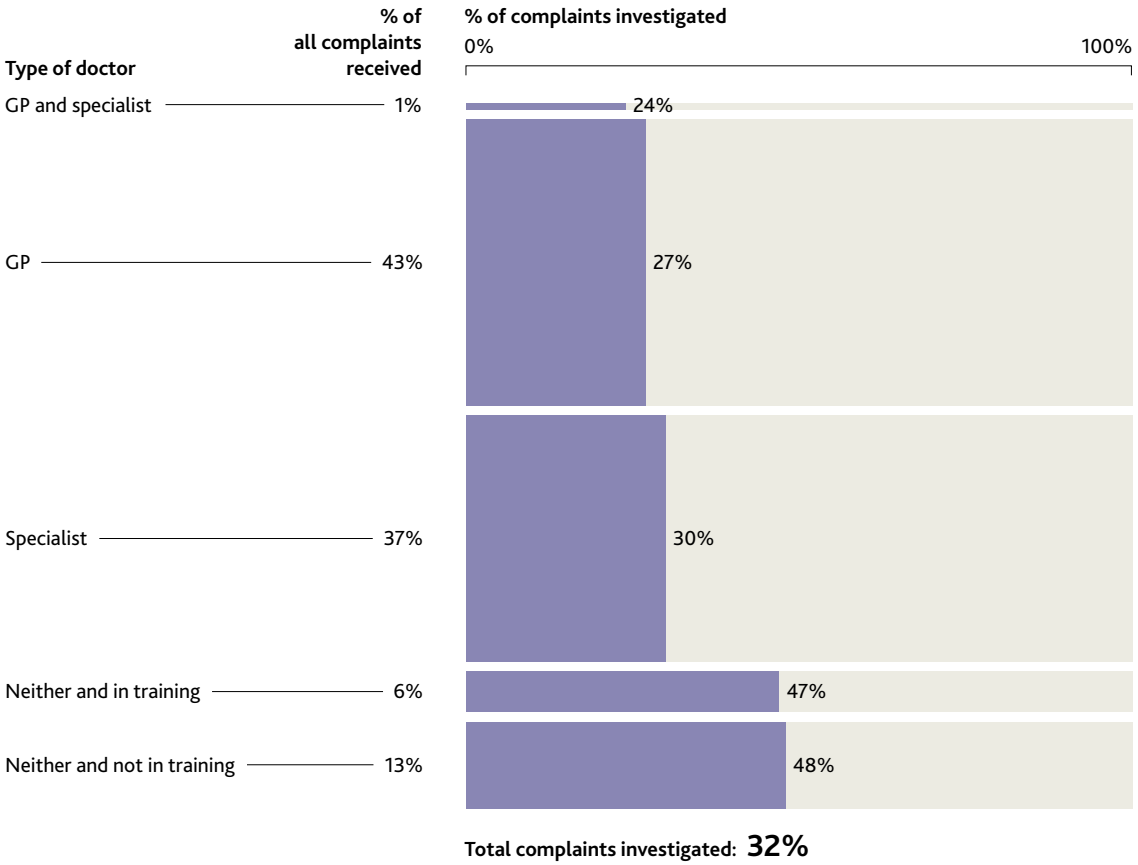


**Figure 40: Proportion of complaints that were investigated in 2015, by type of doctors**



## The need to pool data across years

Because the number of complaints, investigations and sanctions are so small each year, we have to pool several years of data to assess whether any group of doctors has a significantly higher risk than others.

Most of the data in this chapter show the likelihood of a complaint, an investigation, or a sanction or a warning, collectively for the five years from 2011–15. In the case of doctors on neither the GP nor the Specialist Register, we do not have reliable data to split out doctors in training from those who are not in training for 2011, so where we distinguish between these two groups we use 2015 data.

## Interpreting differences between groups in their risk of being complained about and investigated

Complaints come from different sources – in this chapter we look separately at complaints from doctors' employers, other doctors, doctors who have self-referred, members of the public and 'others', which includes the GMC, police and other organisations. Complaints cover a wide variety of issues – for example, they may include allegations about a doctor's clinical competence or dishonesty. For further information on these differences see *The state of medical education and practice in the UK: 2015*.

It is also the case that complaints from different sources have different probabilities of being investigated and investigations about different allegations have different probabilities of resulting in a sanction or a warning.

Some groups of doctors are more likely to have complaints from particular sources, or to be investigated in relation to particular allegations. It is important to bear them in mind when interpreting the differences in the risk of a complaint, an investigation, and a sanction or a warning between different groups of doctors.

We therefore describe in the next two sections how the proportions of complaints coming from different sources and the proportions of investigations that are about different things vary between groups of doctors. This accounts for some of the variation in risks experienced by groups of doctors described in the final part of this chapter.

# Which doctors are complained about by different sources?

We use the term 'complaints' to capture not only complaints from the public, but also concerns raised by doctors' employers, other doctors, self-referred doctors, the police and people acting on behalf of organisations, such as private healthcare groups, health defence organisations, solicitors, health regulators, court services, coroners and overseas regulators.

## Concerns raised by employers are more likely to result in an investigation than complaints from the public

As chapter 3, figure 37 shows, nearly two-thirds of complaints are from the public, but they have a relatively low probability of reaching the thresholds that lead to an investigation. By contrast, less than 10% of complaints come from employers, but a very high proportion of these reach the thresholds needed for an investigation.

## Doctors on the GP and Specialist Registers are twice as likely to be complained about by the public than doctors on neither register

Different types of doctors have a different distribution of complaints coming from different sources (figure 41). Over three-quarters of complaints about doctors on the GP Register and two-thirds of complaints about doctors on the Specialist Register are from the public. Doctors on neither register are subject to a much smaller number of complaints, with complaints from the public accounting for only just over a third. Self-referrals account for over a quarter of the relatively small number of complaints about doctors in training, a much higher proportion than is the case for doctors not in training.

## Doctors who graduated outside the UK have a higher proportion of complaints from employers

As noted in earlier editions of this report, employers are more likely than members of the public to make complaints about black and minority ethnic (BME)* doctors and doctors who graduated outside the UK. Furthermore, among UK graduates referred by employers, more are BME than white.

Figure 42 shows that the relative proportion of complaints from employers is higher for BME international medical graduates (IMGs)† and for white graduates from the European Economic Area (EEA)‡ than for UK graduates. This higher proportion of complaints from employers – whose complaints are more likely to lead to an investigation – may partly account for these groups appearing to be higher risk, as shown later in this chapter.

* BME includes Asian, black, mixed ethnic groups and other ethnic groups.

† 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.

‡ 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.

**Figure 41: Source of complaints about different types of doctors in 2015**

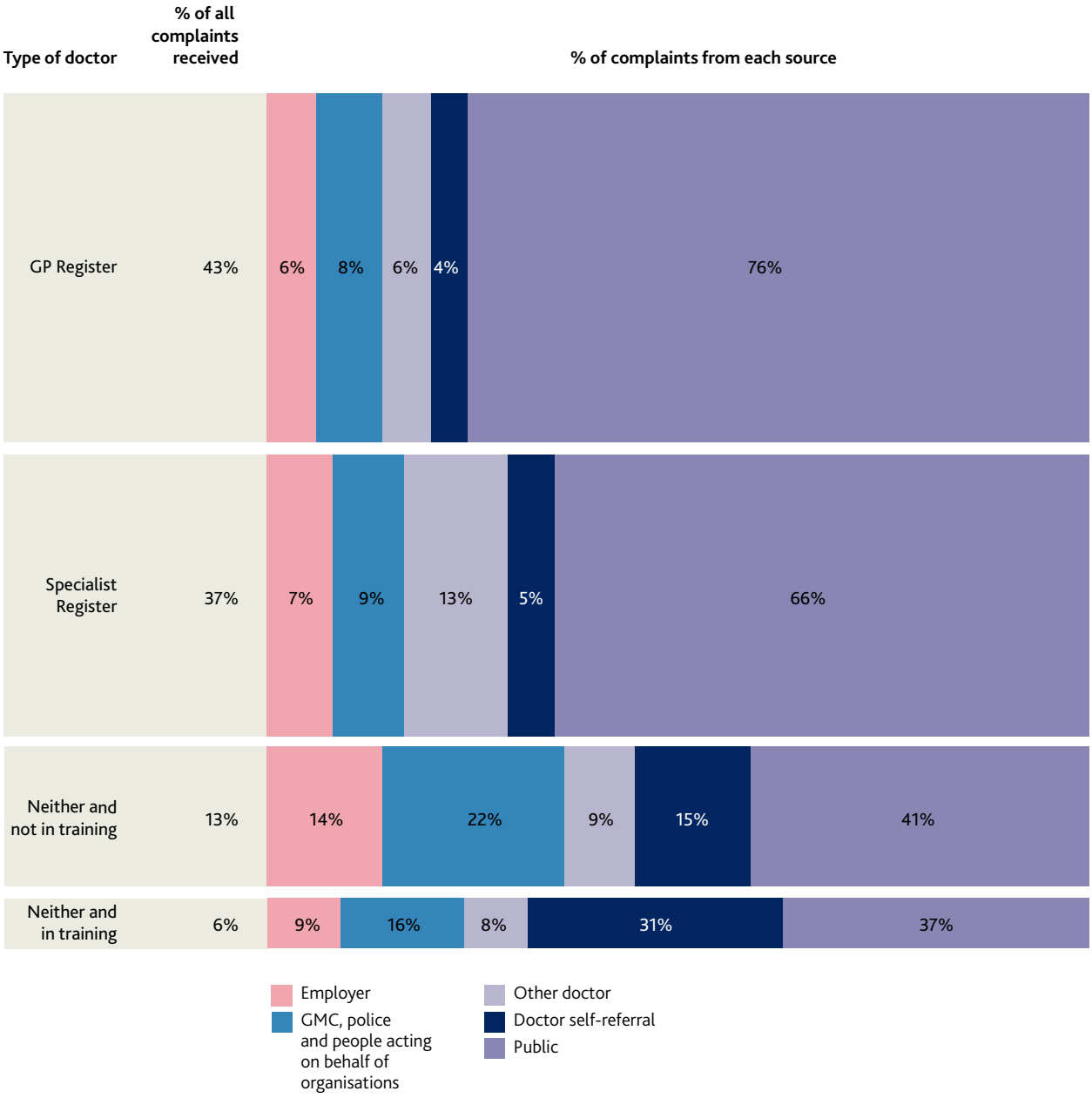
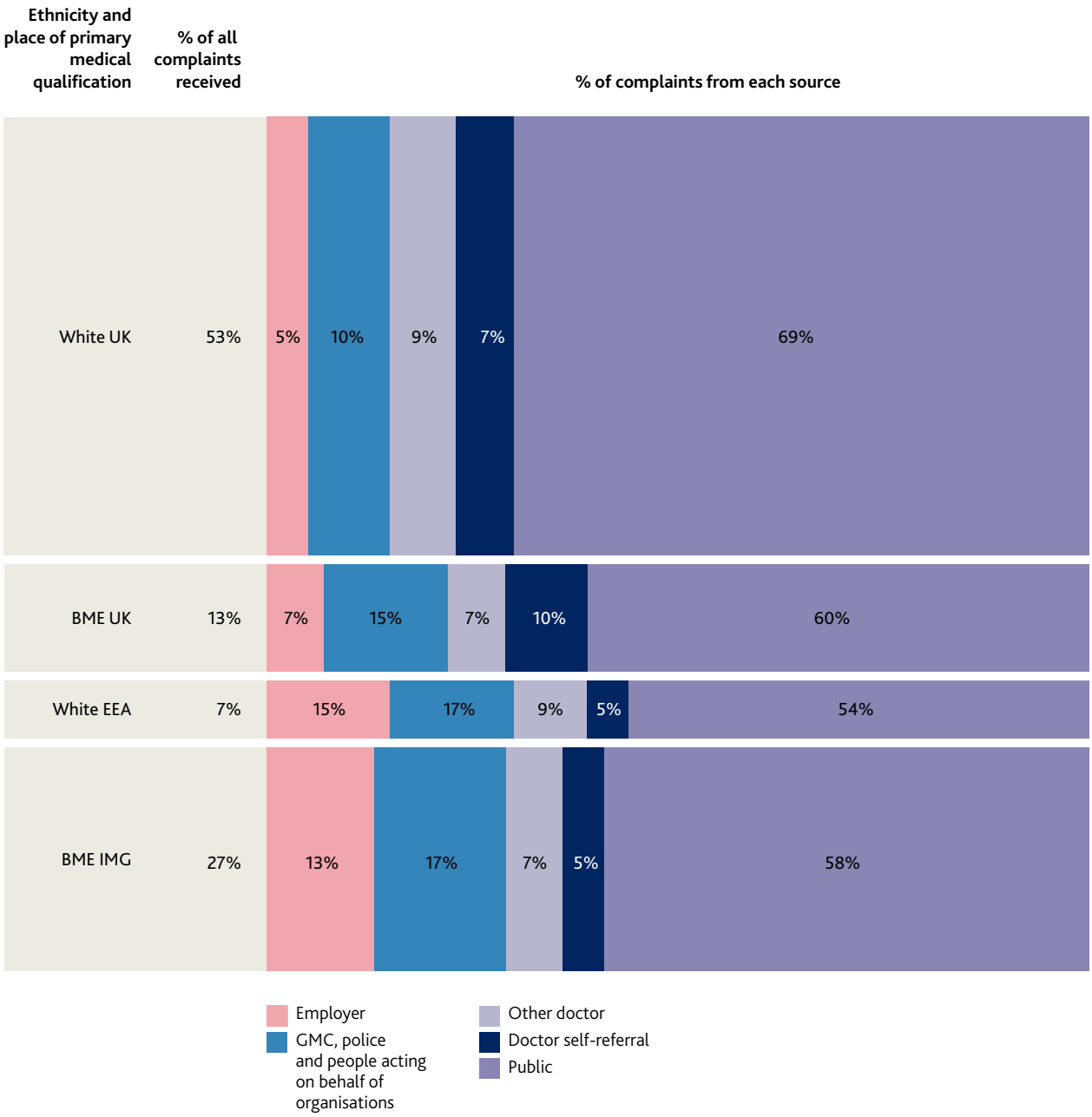


**Figure 42:** Source of complaints in 2011–15, by selected groups of ethnicity and of place of primary medical qualification



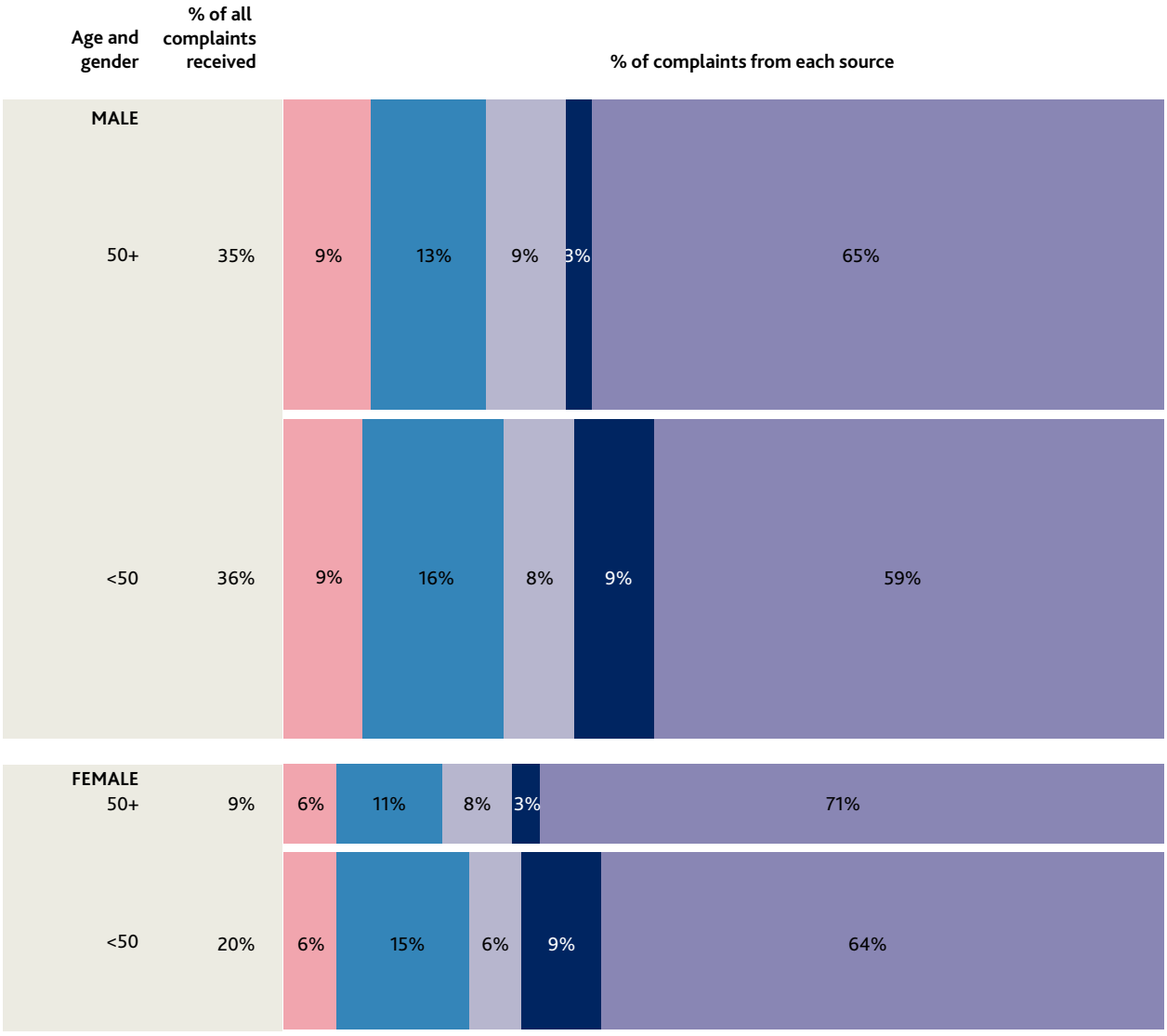
## Male doctors account for a higher proportion of complaints from employers, and younger doctors are more likely to self-refer

The source of a doctor's complaint also varies by a doctor's age and gender.

Figure 43 shows that employers account for a higher proportion of complaints about male doctors than female ones, irrespective of the doctor's age. Doctors under 50 years old are more likely to self-refer than doctors over 50 years old (regardless of their gender).

Male doctors under 50 years old had a smaller share of their complaints from the public compared with female doctors over 50 years old. The relative risk of each group of doctors being complained about, having the complaint investigated, and receiving a sanction or a warning is examined later in this chapter.

**Figure 43: Source of complaints in 2011–15, by gender and age (years)**



# How does the source of the complaint and the type of allegation affect the likelihood of the case resulting in a sanction or a warning?

As cases are investigated, the precise nature of the allegations involved becomes clearer and we record the allegations involved in each investigation. We define over 300 allegations related to a doctor's possible failure to meet the standards expected of them. Every case is unique and may involve a single allegation or different combinations of allegations. To help analyse the different types of cases, we have defined ten broad groups of allegations in box 1. More information on these groups can be found in last year's edition.[21]

## BOX 2: Allegations assigned to different types of cases

When the GMC is investigating a complaint, one or more allegations are assigned to help record what the case is about. We have grouped allegations to define distinct types of cases. Each type of case is mutually exclusive – a case can appear in only one group.

**All health allegations:** these cases are about the doctor's physical or mental health, irrespective of what other allegations may also be involved.

**All criminality allegations except health:** these cases have arisen because of criminal behaviour by the doctor leading to a conviction, irrespective of what other allegations are involved. Only cases with health allegations are excluded – these cases are defined as health allegation cases.

**Acting honestly and fairly allegations *only*:** these cases are *solely* about a doctor's failure to act honestly and fairly towards patients and others. Cases that include other allegations are excluded.

**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 other allegations, but excludes cases with health and criminality allegations (which are covered by the first two types of cases in this list) and cases with clinical competence allegations (which are covered by the next type of case in this list).

**Acting honestly and fairly and clinical competence allegations *only*:** these cases *solely* involve allegations about both a failure to act honestly and fairly and a failure to deliver good-quality clinical care. Cases that include other allegations are excluded.

**Clinical competence allegations *only*:** these cases are *solely* about a doctor's failure to deliver good-quality clinical care to patients. Cases that include other allegations are excluded.

**Clinical competence and communication and respect for patients' allegations *only*:** these cases *solely* involve allegations about both a doctor's failure to deliver good-quality clinical care, and to communicate appropriately and respectfully with patients. Cases that include other allegations are excluded.

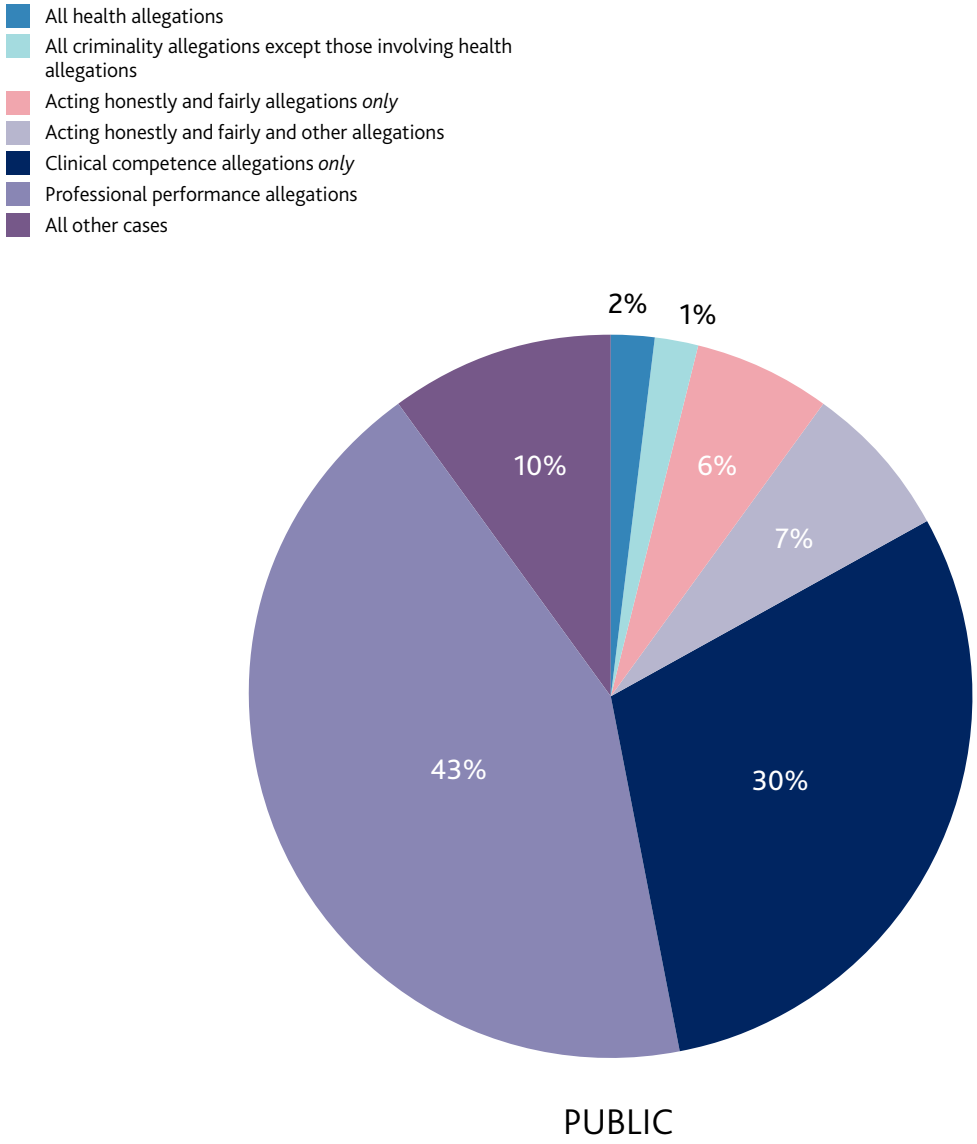
**Communication and respect for patients allegations *only*:** these cases are *solely* about a doctor's failure to communicate appropriately and respectfully with patients. Cases that include other allegations are excluded.

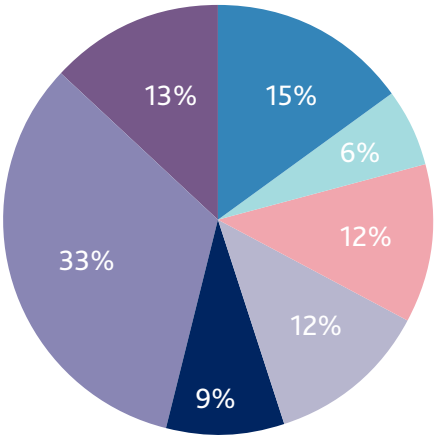
**Professional performance allegations:** these cases are about a doctor's poor performance in the non-clinical aspects of their role – for example, failing to work well with colleagues, failing to appropriately report on cases or share information, or bullying and undermining colleagues. This group may also include cases involving other allegations, but excludes cases with health and criminality allegations (which are covered by the first two types of cases in this list) and cases with honesty and fairness allegations (which are covered by the fourth type of case in this list).

**Cases with other allegations:** these cases are about any allegation or combination of allegations not included in one of the types of cases listed above.

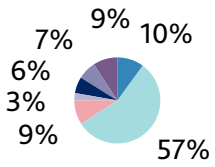
Figure 44 shows that some types of cases are more likely to arise from some sources. Notably, nearly half (45%) of investigated cases stemming from concerns raised by employers involve health, criminality, or honesty and fairness, whereas these types of cases account for only one in six cases (16%) arising from complaints from the public. These types of cases have a much higher probability of resulting in a sanction or a warning than those involving only issues of clinical competence (figure 45), which account for nearly a third (30%) of investigations arising from public complaints but less than one in ten cases (9%) stemming from concerns raised by employers.

**Figure 44: Source of the complaint for different types of investigated cases in 2011–15**

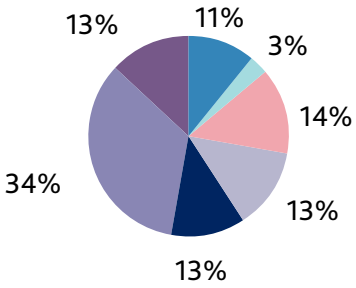




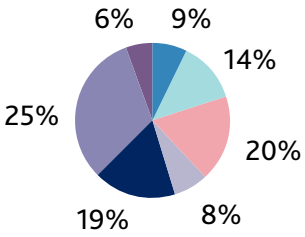

EMPLOYER
2,381 cases



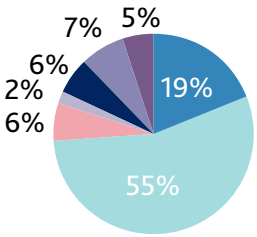

POLICE
484 cases



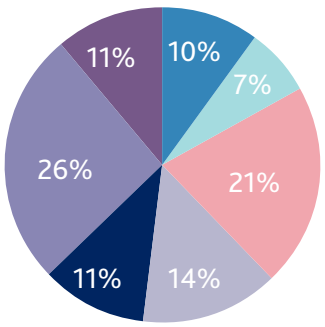

OTHER DOCTOR
1,151 cases




GMC
835 cases

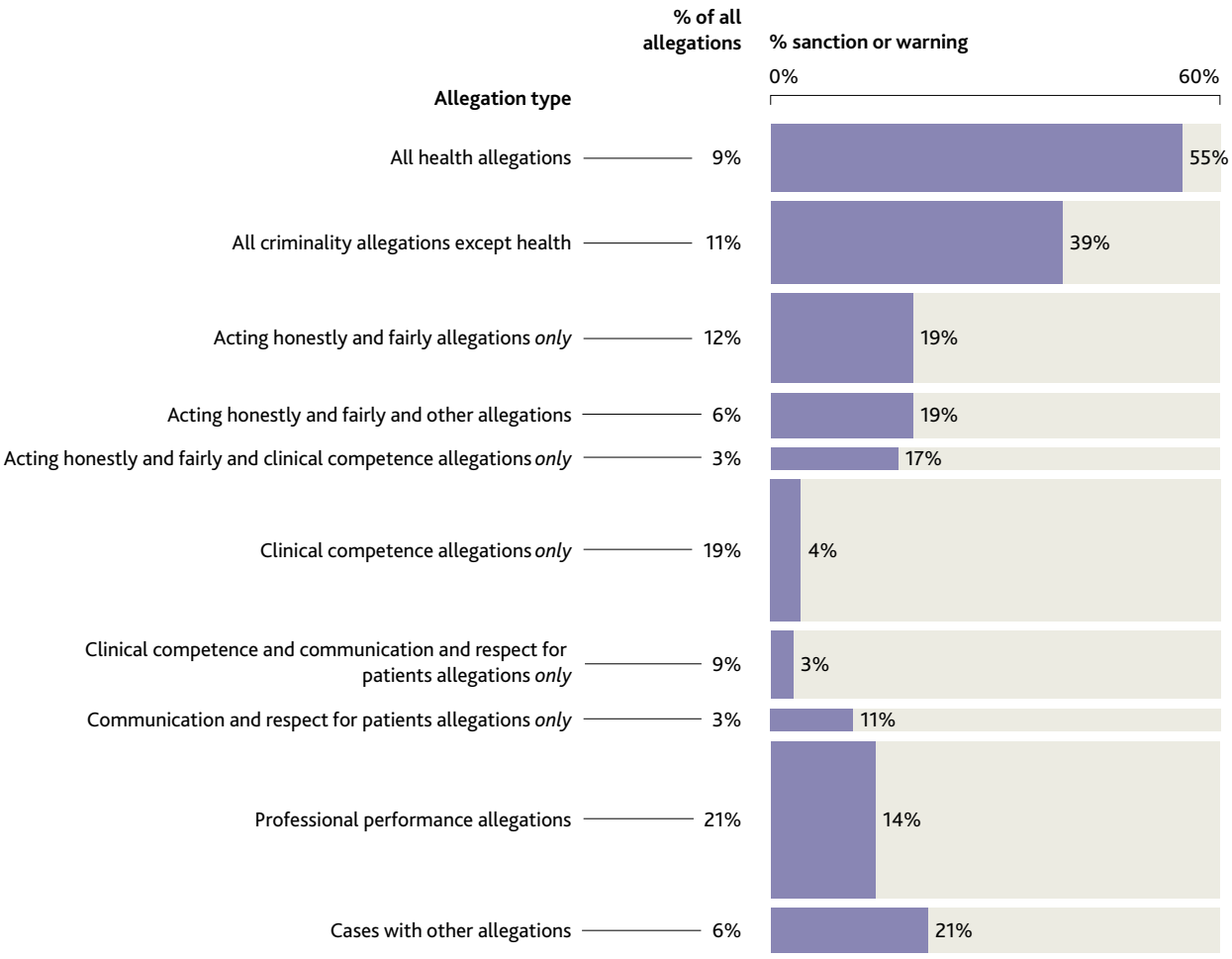



DOCTOR SELF-REFERRAL
1,155 cases




OTHER ACTING ON BEHALF
OF ORGANISATIONS
1,834 cases

**Figure 45: Proportion of different types of cases leading to a sanction or a warning in 2011–15**



# What is the risk of a complaint, an investigation, or a sanction or a warning for different groups of doctors?

A variety of complaints come into the GMC from different sources, some of which lead to an investigation. The most likely source of a complaint and type of case vary across different types and demographic groups of doctors.

In this section, we summarise in broad terms the risk both of being complained about, having the complaint investigated, and receiving a sanction or a warning – first in relation to ethnicity and place of primary medical qualification (table 1, figure 46), and second in relation to age and gender (table 2, figure 46).

In both cases we present the data separately for different types of doctors – those on the GP Register, those on the Specialist Register, and those on neither register. This is because different demographic groups are more concentrated among some types of doctors than among others, so the differences between groups would be masked if we looked at the data for all types of doctors together.

## Even in high-risk groups, the vast majority do not receive sanctions or warnings from the GMC

Less than one in 100 doctors received a sanction or a warning following a GMC investigation during 2011–15. This means that even in groups of doctors with double the risk, the vast majority were not subject to any action from the GMC.

Although the numbers are small, we still need to understand where the risk of a sanction or a warning is heightened and what the causes may be, as this can help to determine whether an intervention could reduce the risks to patient safety.

The 2015 data we have added this year have not changed the broad conclusions we reached previously. Groups at higher risk of being complained about and at higher risk of a sanction or a warning include:

- non-UK graduates (collectively EEA graduates and IMGs)
- BME doctors
- male doctors
- doctors aged 50 years and over.

But, in all of these higher-risk groups, most doctors were not complained about and of those who were very few received a sanction or a warning during 2011–15 (see tables 1 and 2).

## Non-UK graduates and BME doctors are at increased risk of receiving a sanction or a warning

As we showed in chapter 1, most doctors who are registered to work in the UK fall into one of four groups: white UK graduates (42%), IMGs who are BME (17%), UK graduates who are BME (12%), and white EEA graduates (8%). There are then two much smaller groups – white IMGs (3%) and EEA graduates (excluding the UK) who are BME (1%).

The remaining doctors (18%) have not declared their ethnicity to us. We have excluded these doctors from the analysis in this section, but we are confident this does not invalidate the broad differences in risk discussed here. [21]

### All doctors in 2011–15

- Non-UK graduates are more likely to receive a sanction or a warning than UK graduates.
- When comparing doctors with the same place of primary medical qualification (UK graduates, EEA graduates or IMGs), BME doctors are more likely to receive a sanction or a warning than white doctors.
- Both BME and white EEA graduates are more likely to receive a sanction or a warning than their counterparts who graduated elsewhere (UK graduates and IMGs).

### Doctors on the GP Register in 2011–15

- Over a quarter of non-UK graduates and of BME EEA graduates were complained about, compared with a fifth of BME UK graduates and a little less than that for white UK and EEA graduates.
- GPs who are EEA graduates who are complained about, have a higher percentage of receiving a sanction or a warning (6.7% for BME doctors and 7.1% for white doctors) than IMGs (5.1% for BME doctors and 4.2% for white doctors) and UK graduates (4.3% for BME doctors and 3.0% for white doctors).
- Similarly among BME GPs, 1.9% of EEA graduates received a sanction or a warning compared with 1.4% of IMGs and 0.8% of UK graduates. The data follow the same pattern for white doctors: 1.3% of EEA graduates, 1.1% of IMGs and 0.8% of UK graduates received a sanction or a warning.

### Doctors on the Specialist Register in 2011–15

- 13–15% of all six (ethnic/place of primary medical qualification) groups were complained about, except for white EEA graduates where only 9% were complained about.
- Specialists who are EEA doctors are at substantially higher risk of a sanction or a warning than IMGs and UK graduates. This pattern persists among BME doctors (1.4% of EEA graduates, 0.7% of IMGs and only 0.4% of UK graduates) and white doctors (0.9% of EEA graduates, 0.5% of IMGs and 0.4% of UK graduates).

- This result in part reflects the fact that the likelihood of an investigation resulting in a sanction or a warning is more than double for EEA graduates compared with IMGs and UK graduates.

### Doctors on neither register in 2011–15

- Doctors on neither register are much less likely to be the subject of a complaint, but those complaints are more likely to be investigated.

- The small group of EEA graduates who are BME stand out as being much more at risk of a sanction or a warning (2.5% vs ~1% or less of the other five groups). These doctors are much more likely to be complained about (11% vs 8–9% of IMGs and 4–5% of white EEA graduates and of UK graduates), and for those complaints to result in a sanction or a warning (23% – almost twice the proportion of the other five groups).

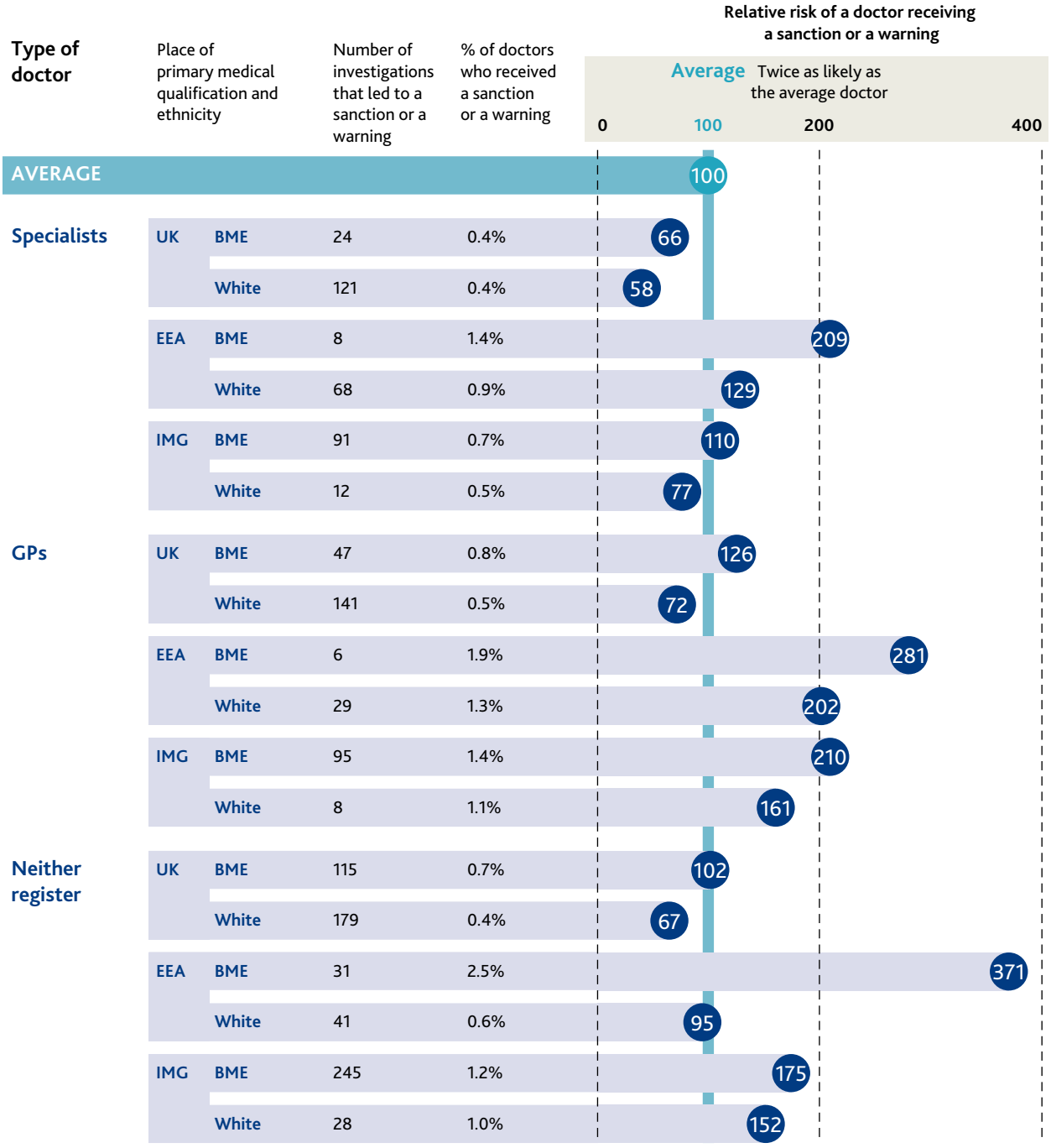
- To a lesser extent, IMGs are more likely to receive a sanction or a warning than UK graduates. However this reflects the fact that a higher proportion of IMGs were complained about in the first place, rather than by differences in the likelihood of those complaints resulting in a sanction or a warning.

**Table 1: Proportion of different types of doctors who were complained about, had a complaint investigated and received a sanction or a warning in 2011–15, by place of primary medical qualification and ethnicity**

| PLACE OF PMQ ETHNICITY | UK | | EEA | | IMG | | Total |
|---|---|---|---|---|---|---|---|
| | BME | White | BME | White | BME | White | |
| **Specialist** | | | | | | | |
| Number on the medical register | 5,448 | 31,249 | 576 | 7,948 | 12,483 | 2,353 | 60,057 |
| % of doctors complained about | 14% | 14% | 13% | 9% | 15% | 15% | 13% |
| % of doctors with a complaint investigated | 37% | 31% | 48% | 46% | 44% | 37% | 36% |
| % of investigations that led to a sanction or a warning | 9% | 9% | 22% | 20% | 11% | 9% | 11% |
| % of complaints ending in a sanction or a warning* | 3.25% | 2.85% | 10.39% | 9.04% | 5.01% | 3.38% | 4.06% |
| % of doctors that received a sanction or a warning | 0.44% | 0.39% | 1.39% | 0.86% | 0.73% | 0.51% | 0.54% |
| **GPs** | | | | | | | |
| Number on the medical register | 5,596 | 29,500 | 322 | 2,163 | 6,794 | 749 | 45,123 |
| % of doctors complained about | 20% | 16% | 28% | 19% | 27% | 25% | 19% |
| % of doctors with a complaint investigated | 35% | 28% | 40% | 39% | 41% | 39% | 33% |
| % of investigations that led to a sanction or a warning | 12% | 11% | 17% | 18% | 13% | 11% | 12% |
| % of complaints ending in a sanction or a warning* | 4.29% | 2.95% | 6.74% | 7.06% | 5.10% | 4.23% | 3.87% |
| % of doctors that received a sanction or a warning | 0.84% | 0.48% | 1.87% | 1.34% | 1.40% | 1.07% | 0.72% |
| **Doctors not on the GP or Specialist Register** | | | | | | | |
| Number on the medical register | 16,992 | 40,311 | 1,257 | 6,489 | 21,042 | 2,771 | 88,862 |
| % of doctors complained about | 5% | 4% | 11% | 5% | 8% | 9% | 6% |
| % of doctors with a complaint investigated | 52% | 46% | 66% | 58% | 60% | 56% | 54% |
| % of investigations that led to a sanction or a warning | 25% | 23% | 34% | 21% | 23% | 21% | 24% |
| % of complaints ending in a sanction or a warning* | 13.07% | 10.52% | 22.63% | 12.50% | 13.88% | 11.62% | 12.65% |
| % of doctors that received a sanction or a warning | 0.68% | 0.44% | 2.47% | 0.63% | 1.16% | 1.01% | 0.72% |

PMQ = primary medical qualification.
Data include doctors of BME or white ethnicity, and exclude doctors of unknown ethnicity.
* The denominator for these percentages includes complaints that are still being assessed and investigated.

**Figure 46:** Risk of different types of doctors receiving a sanction or a warning in 2011–15, by place of primary medical qualification and ethnicity




| Type of doctor | Place of primary medical qualification and ethnicity | | Number of investigations that led to a sanction or a warning | % of doctors who received a sanction or a warning |
|---|---|---|---|---|
| AVERAGE | | | | |
| Specialists | UK | BME | 24 | 0.4% |
| | | White | 121 | 0.4% |
| | EEA | BME | 8 | 1.4% |
| | | White | 68 | 0.9% |
| | IMG | BME | 91 | 0.7% |
| | | White | 12 | 0.5% |
| GPs | UK | BME | 47 | 0.8% |
| | | White | 141 | 0.5% |
| | EEA | BME | 6 | 1.9% |
| | | White | 29 | 1.3% |
| | IMG | BME | 95 | 1.4% |
| | | White | 8 | 1.1% |
| Neither register | UK | BME | 115 | 0.7% |
| | | White | 179 | 0.4% |
| | EEA | BME | 31 | 2.5% |
| | | White | 41 | 0.6% |
| | IMG | BME | 245 | 1.2% |
| | | White | 28 | 1.0% |

## Doctors aged 50 years and over and male doctors are at increased risk of receiving a sanction or a warning

Table 2 confirms that the risk of receiving a sanction or a warning is higher for older and male doctors.

This finding is largely driven by:

- female doctors receiving far fewer complaints than male doctors – particularly in the case of GPs under 50 years old.
- doctors aged 50 years and over being consistently complained about more than younger doctors – this is true of both female and male doctors, across all types of doctors.

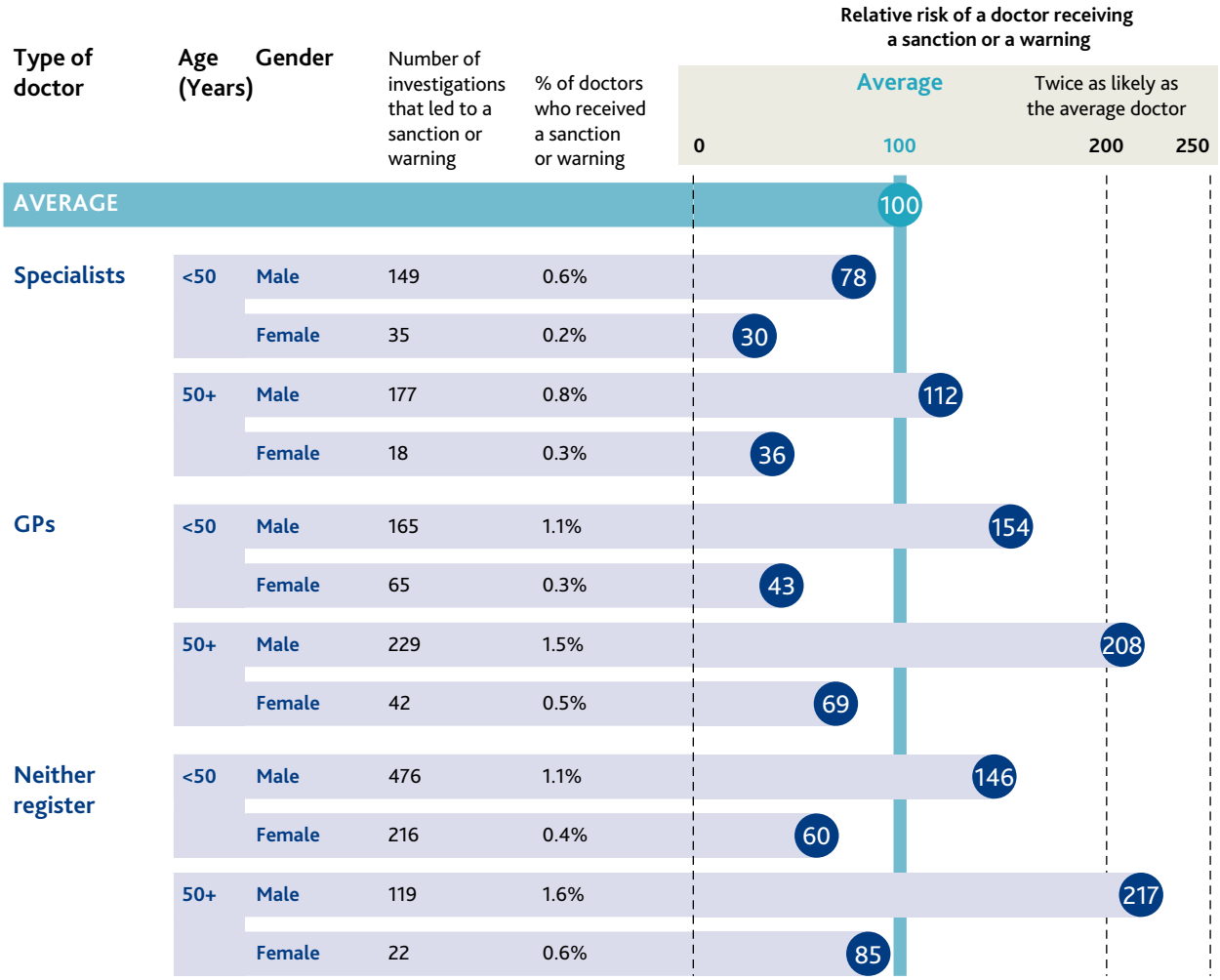
But the probability of a complaint leading to a sanction or a warning is also higher for older and male doctors – again consistently across all types of doctors.

**Table 2: Proportion of different types of doctors who were complained about, had a complaint investigated and received a sanction or a warning in 2011–15, by age and gender**

| AGE | < 50 | | 50+ | | Total |
|---|---|---|---|---|---|
| GENDER | Male | Female | Male | Female | |
| **Specialist** | | | | | |
| Number on the medical register | 26,170 | 15,689 | 21,687 | 6,788 | 70,334 |
| % of doctors complained about | 12% | 7% | 19% | 11% | 13% |
| % of doctors with a complaint investigated | 37% | 31% | 40% | 30% | 37% |
| % of investigations that led to a sanction or a warning | 12% | 10% | 11% | 8% | 11% |
| % of complaints ending in a sanction or a warning* | 4.61% | 3.11% | 4.39% | 2.43% | 4.15% |
| % of doctors that received a sanction or a warning | 0.57% | 0.22% | 0.82% | 0.27% | 0.54% |
| **GPs** | | | | | |
| Number on the medical register | 14,607 | 20,773 | 15,030 | 8,344 | 58,754 |
| % of doctors complained about | 22% | 11% | 29% | 17% | 19% |
| % of doctors with a complaint investigated | 35% | 26% | 38% | 32% | 34% |
| % of investigations that led to a sanction or a warning | 15% | 11% | 14% | 9% | 13% |
| % of complaints ending in a sanction or a warning* | 5.14% | 2.78% | 5.33% | 2.92% | 4.44% |
| % of doctors that received a sanction or a warning | 1.13% | 0.31% | 1.52% | 0.50% | 0.85% |
| **Doctors not on the GP or Specialist Register** | | | | | |
| Number on the medical register | 44,664 | 49,427 | 7,485 | 3,528 | 105,103 |
| % of doctors complained about | 7% | 4% | 13% | 7% | 6% |
| % of doctors with a complaint investigated | 59% | 47% | 58% | 51% | 55% |
| % of investigations that led to a sanction or a warning | 26% | 24% | 21% | 18% | 24% |
| % of complaints ending in a sanction or a warning* | 15.29% | 11.41% | 11.96% | 8.94% | 13.33% |
| % of doctors that received a sanction or a warning | 1.07% | 0.44% | 1.59% | 0.62% | 0.79% |

* The denominator for these percentages includes complaints that are still being assessed and investigated.

Figure 47: Risk of different types of doctors receiving a sanction or a warning in 2011–15, by gender and age (years)



# Chapter five:
# Regional differences in the types of doctors

In this chapter we look at variations in how the medical workforce is deployed and distributed across the UK.

The analysis includes the number of doctors per person for different types of doctor. We also examine the diversity of doctors across the UK, and the age profile of different types of doctors to understand whether our data can corroborate reported issues of an ageing workforce in specific geographical areas.

The maps are shaded so that darker areas indicate the greatest variation. Box 1 explains how we have allocated doctors to the four UK countries and to regions in England. Detailed data for each country and region are in the reference tables.*

* The reference tables are available at www.gmc-uk.org/somep2016

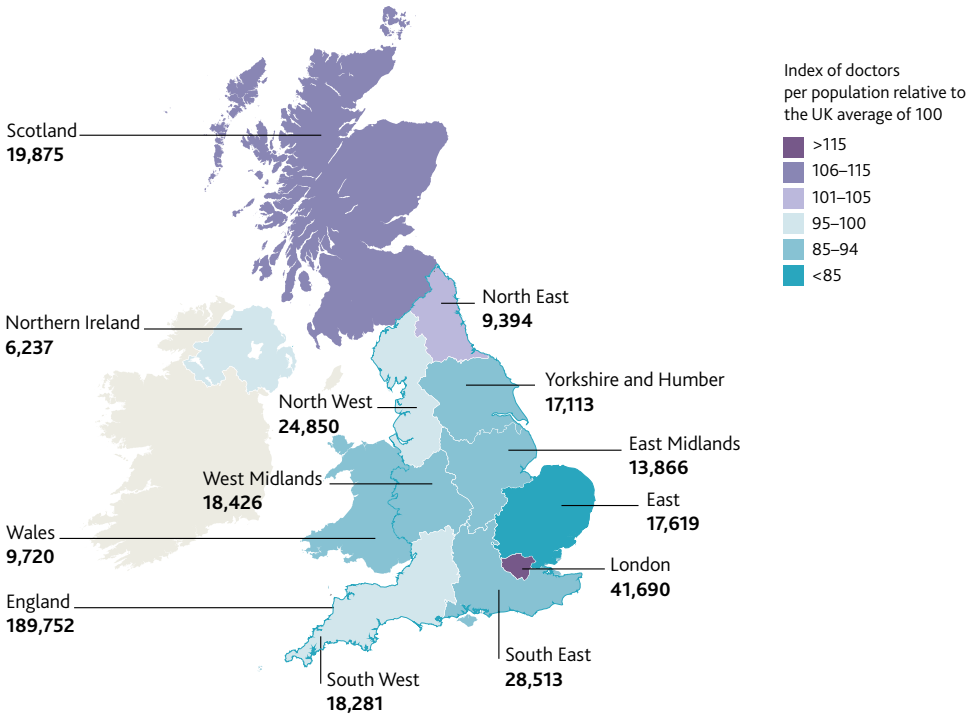
# How many doctors are there across the UK?

## BOX 3: Data for doctors across different parts of the UK

We have been able to allocate 96% of doctors on the medical register to one of the four parts of the UK or to a region of England (figure 48). A new method has been used to improve how we capture and locate doctors, but this means that the data are not directly comparable with previous figures. For doctors working in the NHS we have used their workplace address.

For doctors in training, without a valid workplace address, we have used the address of their workplace given in the GMC's national training survey. For doctors not in training, we have used the address of the organisation they are linked to for revalidation. Where organisations cannot be linked to a UK country or a region of England – for example, because the address is for a head office or national body – we have used the correspondence address held for the doctor.

**Figure 48: Number of licensed doctors relative to the population in 2015**




Data are based on mid-year population estimates for 2015.[65]
Excludes 4% of licensed doctors with unknown location unless otherwise specified.

## Wales has fewer GPs than Northern Ireland despite similar density

We have used an index of GPs per person in each country or region to investigate the density of GPs across the UK (figure 49).

Relative to the UK average of 100, there are fewer GPs per person in Wales (90) than in Scotland (121) and England (98), but also fewer than in Northern Ireland, which has a similar population density per km$^2$.

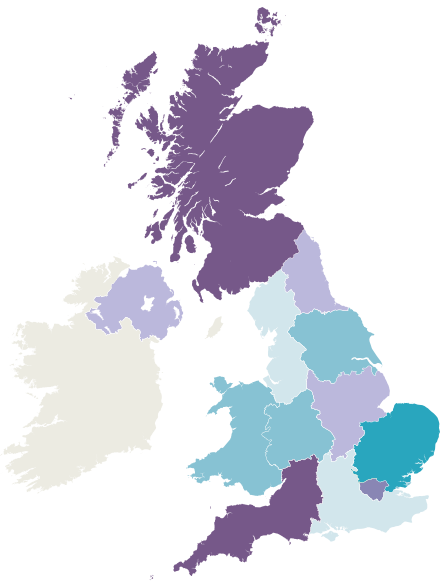
**Figure 49: Number of different types of licensed doctors relative to the population in 2015***

| Part of the UK | Doctors on the GP Register: Number of doctors | Doctors on the Specialist Register: Number of doctors |
|---|---|---|
| **Wales** | 2,552 | 3,060 |
| **Scotland** | 5,909 | 6,183 |
| **Northern Ireland** | 1,733 | 1,855 |
| **England** | 49,135 | 58,719 |
| North East | 2,458 | 3,115 |
| North West | 6,399 | 7,670 |
| Yorkshire and Humber | 4,544 | 5,263 |
| East Midlands | 4,336 | 3,808 |
| West Midlands | 4,720 | 5,636 |
| East | 4,619 | 5,504 |
| London | 8,342 | 13,627 |
| South East | 7,838 | 8,767 |
| South West | 5,879 | 5,329 |
| **UK** | 59,329 | 69,847 |
| **UK (including doctors with unknown location)** | **63,319** | **73,275** |

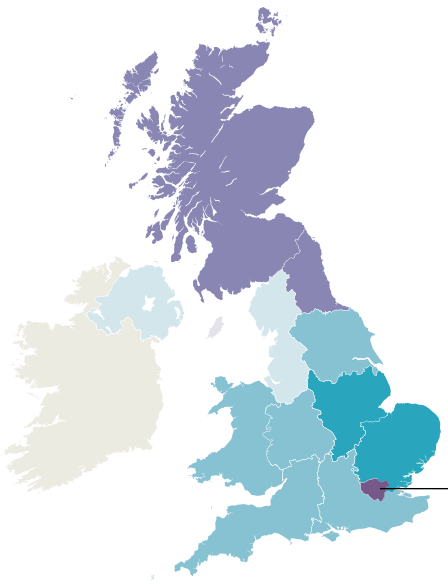
Number of doctors per 100,000 people: 50, 100, 150

>115
106–115
101–105
95–100
85–94
<85

Index of GPs per population relative to UK average of 100



Index of specialists per population relative to UK average of 100



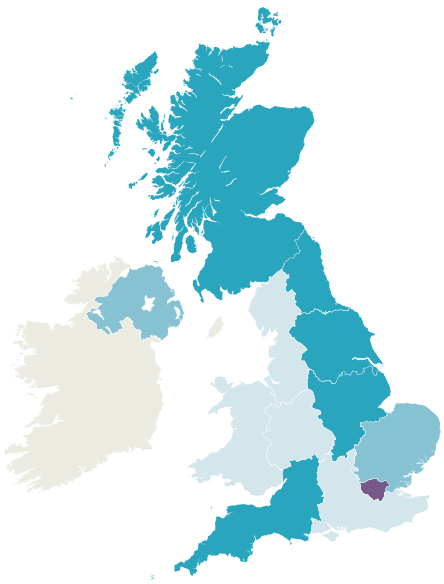
* Excludes doctors with unknown location unless otherwise specified, so 5.2% of all licensed doctors not in training, 10.9% of doctors on neither register and not in training, 1.6% of doctors on the GP Register, and 4.7% of doctors on the Specialist Register.

This difference may indicate different health needs and health systems in these areas, or lower use of GPs in Wales. These data are not able to show whether there are any capacity issues in the workforce, though the Welsh government is planning a campaign to increase GP numbers.[66]

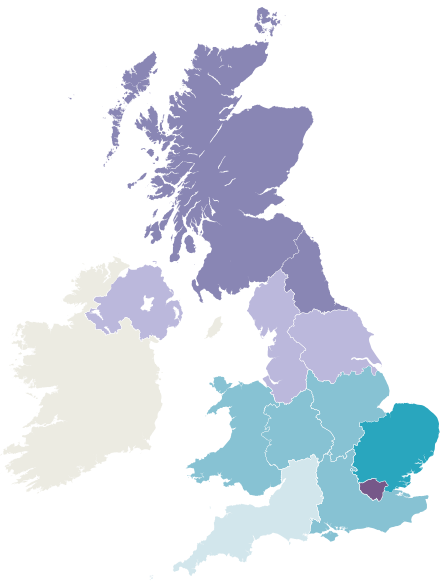
There is also some variation in the level of GPs per person across the regions of England with the East having the lowest index score of 83, and the South West with 118.

| Part of the UK | Doctors not on the GP or Specialist Register ** Number of doctors | Doctors not on the GP or Specialist Register ** Number of doctors per 100,000 people | Doctors in training Number of doctors | Doctors in training Number of doctors per 100,000 people |
|---|---|---|---|---|
| **Wales** | 1,758 | | 2,405 | |
| **Scotland** | 2,367 | | 5,539 | |
| **Northern Ireland** | 931 | | 1,721 | |
| **England** | 33,395 | | 49,473 | |
| North East | 1,200 | | 2,657 | |
| North West | 4,135 | | 6,745 | |
| Yorkshire and Humber | 2,439 | | 4,946 | |
| East Midlands | 2,145 | | 3,637 | |
| West Midlands | 3,398 | | 4,759 | |
| East | 3,131 | | 4,483 | |
| London | 9,324 | | 10,578 | |
| South East | 5,165 | | 6,943 | |
| South West | 2,458 | | 4,725 | |
| **UK** | 38,451 | | 59,138 | |
| **UK (including doctors with unknown location)** | **43,147** | | **59,250** | |

Index of doctors on neither register per population relative to UK average of 100



Index of doctors in training per population relative to UK average of 100



There are substantially more specialists per person in London than in any other country or region, potentially reflecting the concentration of specialists in areas like Harley Street and in the many teaching and specialist hospitals.

# How diverse are doctors across the UK?

## Wales is furthest away from female-male parity

Scotland and Northern Ireland have both reached gender parity, with female doctors making up 51% and 50% of all licensed doctors respectively (figure 50). By contrast, 46% of licensed doctors in England and 44% in Wales are female.

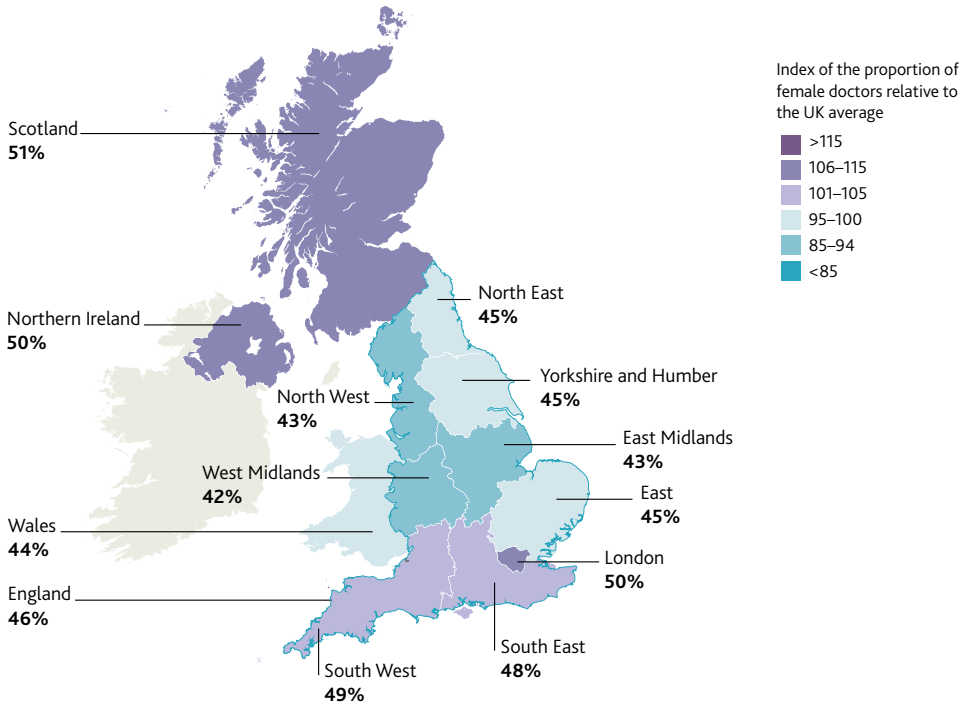
## Northern Ireland and Scotland have the fewest BME doctors

As we saw in chapter 2, UK graduates are ethnically diverse. But there are also country and regional variations: unsurprisingly, the proportion of BME* doctors is higher in countries with higher BME populations.

Northern Ireland and Scotland have very low proportions of BME doctors and non-UK graduates compared with the UK average, whereas England has the highest proportions of both.

The regions in England with the highest proportions of non-UK graduates are the West Midlands and East (40% each). The region with the lowest proportion is the South West (18%), which has similar proportions to Scotland and Northern Ireland (17% and 15% respectively).

Figure 50: **Proportion of female doctors in 2015**




* Black and minority ethnic doctors (BME) includes Asian, black, other ethnic groups and mixed ethnic groups.

**Figure 51: Proportion of licensed doctors who are BME in 2015**

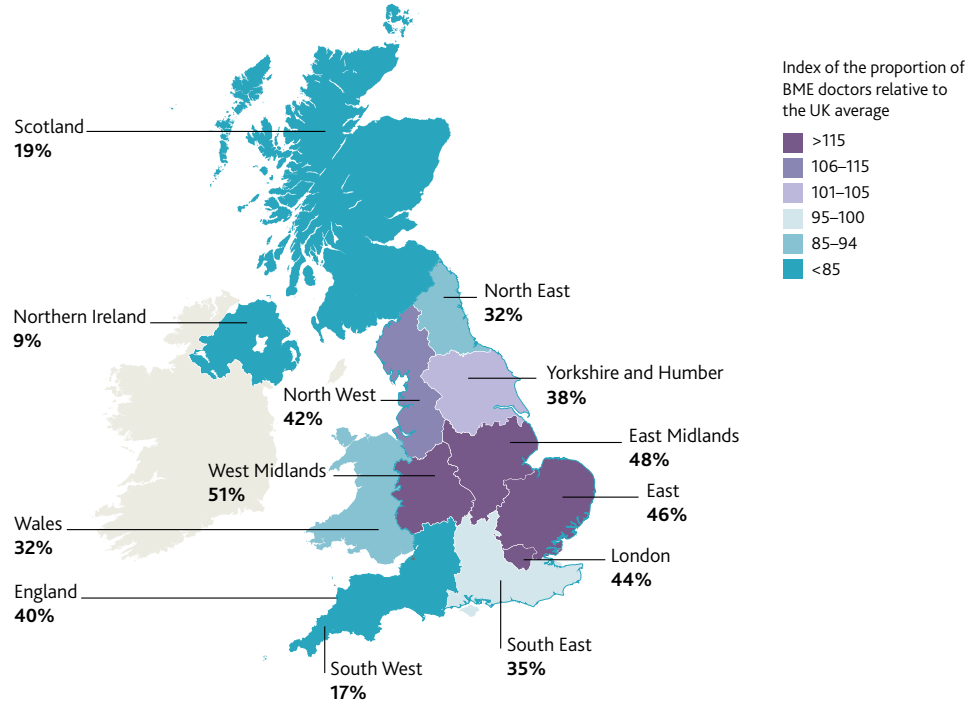
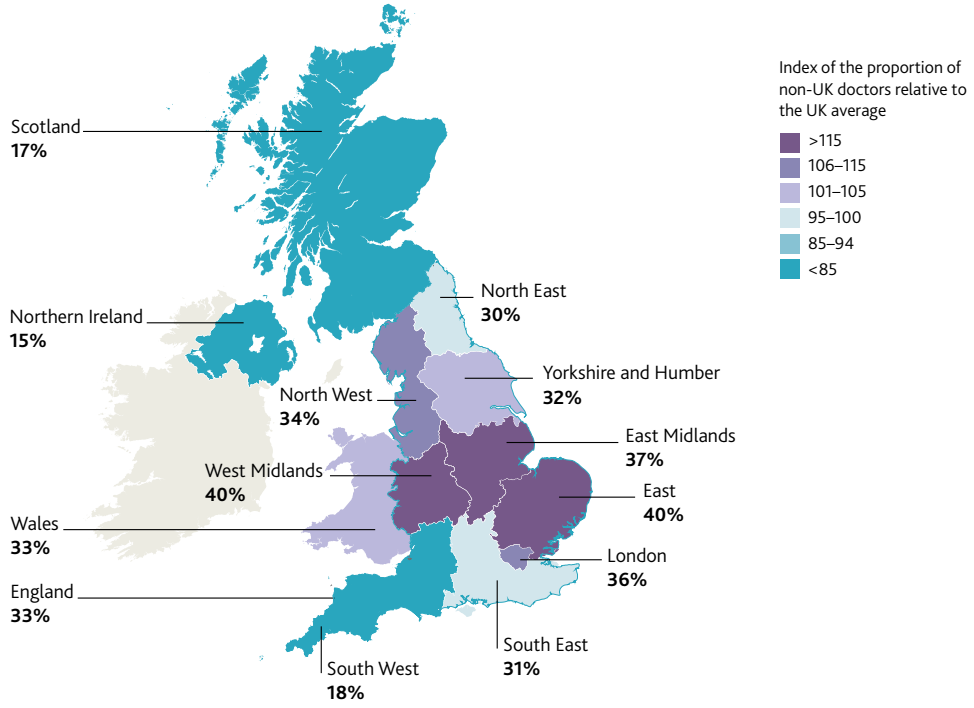



**Figure 52: Proportion of licensed doctors who have non-UK primary medical qualifications in 2015**



# What is the age profile of doctors across the UK?

## The age profile varies little across the UK

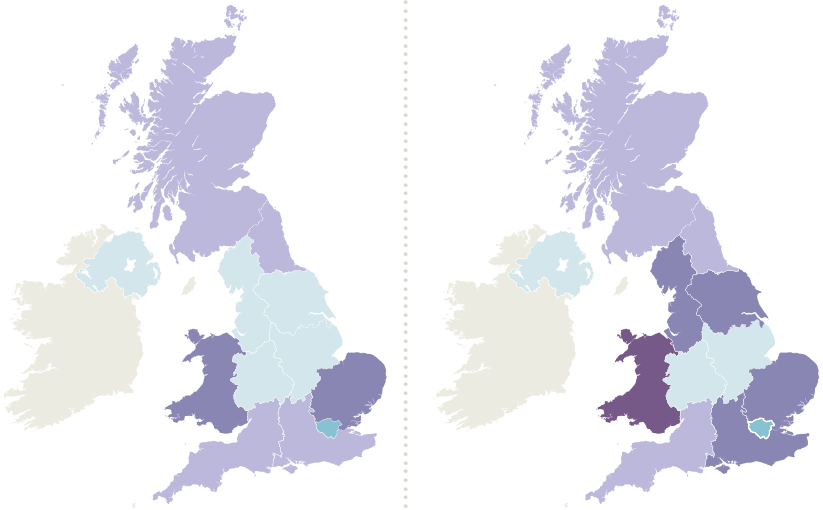
There is relatively little variation in the age profile of licensed doctors not in training across the UK countries and regions of England. Slightly more of the doctors in Wales are aged 50 years or older – 28% of the licensed doctors in Wales not in training are aged 50–59 years, compared with a UK average of 25%.

**Figure 53: Age profile of doctors by country and type of registration***

| Part of the UK | All licensed doctors not in training: Number of doctors | Age (years) <40 | 40–49 | 50–59 | >60 | Doctors on neither register and not in training: Number of doctors | Age (years) <40 | 40–49 | 50–59 | >60 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Wales** | 7,370 | 27% | 34% | 28% | 11% | 1,758 | 47% | 27% | 18% | 8% |
| **Scotland** | 14,459 | 30% | 33% | 28% | 8% | 2,367 | 54% | 23% | 16% | 6% |
| **Northern Ireland** | 4,549 | 34% | 31% | 25% | 9% | 931 | 58% | 22% | 15% | 5% |
| **England** | 141,249 | 31% | 33% | 25% | 11% | 33,395 | 54% | 24% | 14% | 7% |
| North East | 6,773 | 30% | 34% | 27% | 10% | 1,200 | 54% | 24% | 16% | 7% |
| North West | 18,204 | 31% | 34% | 25% | 10% | 4,135 | 51% | 27% | 16% | 7% |
| Yorkshire and Humber | 12,246 | 29% | 35% | 27% | 9% | 2,439 | 53% | 25% | 16% | 7% |
| East Midlands | 10,289 | 30% | 34% | 26% | 10% | 2,145 | 53% | 26% | 14% | 7% |
| West Midlands | 13,754 | 31% | 34% | 25% | 10% | 3,398 | 51% | 29% | 14% | 6% |
| East | 13,254 | 27% | 35% | 27% | 11% | 3,131 | 51% | 26% | 16% | 7% |
| London | 31,293 | 36% | 31% | 20% | 13% | 9,324 | 61% | 21% | 11% | 7% |
| South East | 21,770 | 30% | 34% | 26% | 11% | 5,165 | 52% | 25% | 15% | 8% |
| South West | 13,666 | 29% | 34% | 28% | 9% | 2,458 | 55% | 23% | 15% | 7% |
| **UK** | 167,627 | 31% | 33% | 25% | 10% | 38,451 | 54% | 24% | 14% | 7% |
| **UK (including doctors with unknown location)** | **176,741** | 31% | 33% | 25% | 11% | **43,147** | 55% | 24% | 14% | 7% |

Index of the proportion of doctors aged 50 years and over relative to the UK average of 100

- >115
- 106–115
- 101–105
- 95–100
- 85–94
- <85



London has the highest proportion of doctors who are aged 60 or older (13% compared with the UK average of 10%), but the difference is relatively small.

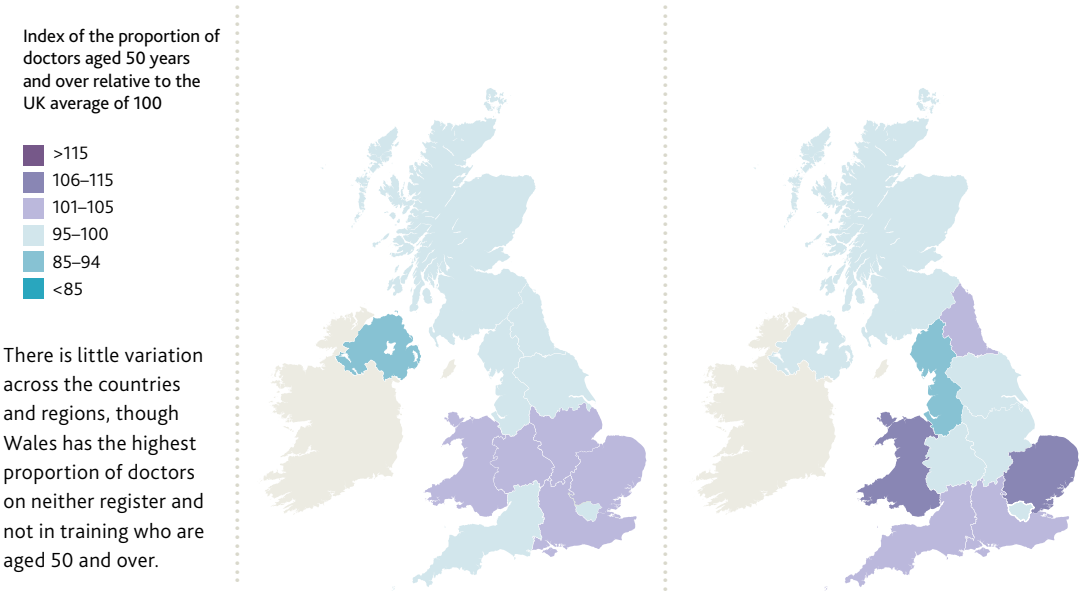
* Excludes doctors with unknown location unless otherwise specified, so 5.2% of all licensed doctors not in training, 10.9% of doctors on neither register and not in training, 1.6% of doctors on the GP Register, and 4.7% of doctors on the Specialist Register.

## GPs in Wales are only slightly older than the UK average

Overall, the age profile of GPs varies little between the countries and regions, though Northern Ireland has the youngest GP workforce and Wales has the oldest.

The British Medical Association and others have warned of a perfect storm in Wales where ageing GPs in rural areas may retire, leaving shortages in those areas.[67] Our data cannot support or discount this scenario, as data limitations mean we are not able to look at the smaller rural areas of Wales. But the data do show that GPs in Wales as a whole are only 4 percentage points more likely to be aged 50 and over than in the UK overall (43% vs 39%).

| Part of the UK | Doctors on the Specialist Register: Number of doctors | Age (years) <40 | 40-49 | 50-59 | >60 | Doctors on the GP Register: Number of doctors | Age (years) <40 | 40-49 | 50-59 | >60 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Wales** | 3,060 | 15% | 42% | 31% | 12% | 2,552 | 29% | 28% | 31% | 12% |
| **Scotland** | 6,183 | 20% | 40% | 30% | 9% | 5,909 | 31% | 30% | 31% | 8% |
| **Northern Ireland** | 1,885 | 22% | 40% | 27% | 11% | 1,733 | 36% | 27% | 29% | 8% |
| **England** | 58,719 | 18% | 41% | 29% | 12% | 49,135 | 31% | 30% | 27% | 11% |
| North East | 3,115 | 20% | 41% | 29% | 10% | 2,458 | 30% | 30% | 29% | 11% |
| North West | 7,670 | 19% | 41% | 29% | 11% | 6,399 | 34% | 30% | 26% | 11% |
| Yorkshire and Humber | 5,263 | 17% | 43% | 30% | 10% | 4,544 | 31% | 31% | 28% | 9% |
| East Midlands | 3,808 | 17% | 41% | 32% | 10% | 4,336 | 31% | 32% | 27% | 10% |
| West Midlands | 5,636 | 16% | 42% | 31% | 11% | 4,720 | 33% | 29% | 26% | 12% |
| East | 5,504 | 15% | 42% | 30% | 13% | 4,619 | 26% | 32% | 31% | 11% |
| London | 13,627 | 19% | 40% | 27% | 14% | 8,342 | 37% | 26% | 21% | 16% |
| South East | 8,767 | 17% | 41% | 29% | 13% | 7,838 | 29% | 31% | 30% | 11% |
| South West | 5,329 | 17% | 43% | 30% | 10% | 5,879 | 29% | 31% | 31% | 9% |
| **UK** | 69,847 | 18% | 41% | 29% | 12% | 59,329 | 31% | 30% | 28% | 11% |
| **UK (including doctors with unknown location)** | **73,275** | 18% | 41% | 29% | 12% | **60,319** | 31% | 30% | 28% | 11% |




There is little variation across the countries and regions, though Wales has the highest proportion of doctors on neither register and not in training who are aged 50 and over.

# Chapter six:
# The future of healthcare regulation in the UK

# Why change?

The GMC has been regulating doctors for almost 160 years. At a functional level our purpose is clear and not much has changed. Our objective is to protect patients and the public. We do that by overseeing the education of students and doctors in training; by licensing doctors to practise when they qualify; by setting standards for professional practice; by making sure doctors maintain those standards; and by taking action through our fitness to practise procedures when they do not.

But how we understand our role in protecting the public must be shaped by the expectations of the society on whose behalf we regulate, while at the same time retaining the consent of the doctors who fund us. Those expectations are not fixed. They have changed radically over the past 20 years and will continue to do so in years to come. That means we must constantly review and refresh the way we regulate so that we remain relevant and effective.

160 years ago it was enough for regulation to make sure the public could distinguish the qualified from the quacks. Today, medicine and the healthcare systems are more complex. The benefits for patients and the public are considerable, but so too are the risks and challenges.

As patients we expect great care and want assurance that we will receive it.[68] We want more and better information about our care. We want the system to be open and honest with us when things have gone wrong, and to prevent them happening again. These are reasonable demands, but they put significant pressure on healthcare professionals working within a system that is visibly under strain.

## Increased expectations of regulators

For the regulator this creates a tension and increased expectations. We need to support doctors in providing the great care that is expected of them, and they must be confident that we will do so. Traditionally, regulators have been associated largely with taking action against professionals who fall below expected standards. That is a necessary part of the job, but the reality is that the vast majority of professionals (who treat the vast majority of patients) will never fall foul of their regulator. Regulation must be relevant to their practice and not an unnecessary burden, an occupational hazard, or a threat.

Regulation must also understand the complex interplay between the practice of individual professionals and the wider systemic pressures of the healthcare environment. Our job is to regulate individual doctors, but we can only do that in a way that is relevant and effective by recognising the effect of the system upon individual practice. We must also recognise that, as a regulator, we are part of the wider patient safety system, so we must work collaboratively to support good practice and minimise the risks of harm.

## Protecting patients

None of this detracts from our primary duty to protect patients. The best way to do that is not by taking action when things have gone wrong and patients (and often doctors themselves) have already been harmed. It is by directing our resources to support good practice and, where we can, mitigate the risks of harm occurring.

If we were in any doubt that regulation must be constantly refreshed and refocused we need only remind ourselves of some of the events that have driven regulatory change in just the past 15 years: the 2001 Bristol Royal Infirmary Inquiry, the Shipman Inquiry in 2005 and the 2013 Mid Staffordshire NHS Foundation Trust Public Inquiry, for example.

The 2007 government report Trust, *Assurance and Safety: the regulation of health professionals in the 21st century*[69] ushered in a new era of professionally led regulation and, more recently, partnership regulation, which have reflected a need to give greater voice to the public.

Most recently, in 2011 the Law Commissions were tasked with developing a new legal framework that would give regulators more agility and autonomy to respond to society's changing needs.[70] That work may now be taken forward by the Department of Health (England) within its review of the future shape of professional regulation. The task for us, meanwhile, is to get ahead of the regulatory curve. This will bring difficult choices, both for us and for society about the sort of regulation it wants.

# Improvement or assurance

## Promoting professionalism

For those who see the primary purpose of regulation as being to act against the minority who fail to meet professional standards, the focus will always be upon setting and enforcing minimum standards of practice. That may ensure minimum compliance but it is only part of the story. We do not aspire to educate medical students to be adequate and nothing more. We rightly expect the health professionals to whom we entrust our care to be more than minimally competent.

Instead we seek to instill the standards of behaviour of good medical practice. Our proposals for a new medical licensing assessment support this approach, while allowing medical schools the flexibility to go beyond our requirements if they wish to do so.[42] The proper aim of regulation, therefore, should go beyond the assurance that practising doctors are not 'bad', and promote the sort of professionalism that most of us would want to take for granted.

This has been the direction of travel for professional regulation since the first publication of our guidance for doctors, *Good medical practice*, in 1995, and it is set to continue. But there are those who regard this as regulatory mission creep. They suspect regulators of muscling in on the responsibilities of employers and of professionals themselves and imposing an unwanted regulatory burden. But it doesn't have to be that way.

Supporting high standards is not the same as delivering improvement. It is doctors themselves and their employers, not the GMC, who deliver improvement. Much of the outreach work of our Regional Liaison Service (RLS) and teams in Scotland, Wales and Northern Ireland has been to explore with groups of doctors the practical application of our standards in their working lives. In 2015, we ran workshops across the UK involving 16,733 doctors and 18,493 medical students. Almost 96% of those who responded to requests for feedback said that the session they attended would help them reflect on their practice and 75% said they would change their practice as a result. Crucially, these sessions are organised around the feedback we receive from doctors themselves so that sessions are tailored to their needs and local circumstances.

### Preventing harm

The work of our RLS and offices in Scotland, Wales and Northern Ireland is a good example of regulating upstream and promoting good practice across the profession. The same is true of our work in medical education and training, and revalidation. This work will be increasingly important in the years ahead. Not only does it help make regulation relevant to a far larger number of doctors than will ever engage with our fitness to practise processes, it tackles what would otherwise be a failure at the heart of regulation.

If our job is to protect patients from harm, then it does not make sense to devote 60% of our resources to dealing with fitness to practise issues where some form of harm has already happened. Not only does this model fail to prevent harm, it may even contribute to it.

A patient has been harmed regardless of whether we take fitness to practise action against a doctor. Most complaints to the GMC are closed without action against the doctor concerned, often leaving the complainant dissatisfied and distrustful of the regulator. Nevertheless, the way our legislation is currently framed requires us to investigate disproportionately large numbers of doctors whose fitness to practise is not ultimately found to be impaired.

We must not underestimate the degree to which this is injurious to the doctors involved and to their confidence in the fairness of regulation. In part the solution will be to reframe the legislation so that matters that should be dealt with locally are dealt with at a local level and in a proportionate manner. This should help us to direct more of our resources towards positive regulatory interventions that promote good practice.

## Risk-based regulation

Regulation was once a largely undiscriminating activity. It was applied in the same way to all those who were being regulated, be they individuals or organisations. It is broadly true of, for example, revalidation today. Following the work of the Better Regulation Executive, regulators have been increasingly focused on making sure their regulatory activities are guided by an understanding of risk in the regulated area.

This has many attractions. It allows regulators to target their limited resources to where they can be most effective. It can help reduce the burden of regulation on others where risks are low because regulation can be less intrusive in these areas. It offers a more proportionate regulatory

response to problems.[71] Above all, it enables regulators to put in place interventions that will prevent risks materialising as actual harms, or at least mitigate the effects of those harms should they occur.[72, 73]

### The challenges of risk-based regulation

Adopting a risk-based approach to regulation brings many challenges. It is dependent upon the existence of reliable data, and the correct understanding of those data, to target regulatory interventions effectively and fairly. For example, if the evidence points towards doctors being more likely to experience professional difficulties at particular points of transition in their career, it may be possible to work with others to put in place supportive and preventative measures that help address this.

There is a long way still to go, but some of the building blocks to enable the better collection and use of data are now in place. We have worked in partnership with others from across the health and education sectors to develop the UK Medical Education Database. This combines data from a range of sources to create a body of information about the performance of medical students and doctors in training throughout their careers. This will support better understanding of such things as medical demographics, recruitment into specialties, career trajectories, the impact of accelerated entry courses, and predictors of fitness to practise trends.

Such approaches rely on doctors and wider society being comfortable with regulators gathering, holding and using data for this purpose. Yet society's legitimate concerns about how individuals' data are used are well documented. We will need to be open and transparent about our plans in this area, and there must be strong governance surrounding the way data may be used. But the potential for more effective, efficient and proportionate regulation in the future is significant.

## Collective assurance

The UK is not short of improvement agencies, assurance bodies and regulators. What those bodies have often failed to do effectively (both in the health sector and elsewhere) is share data and intelligence, and work collaboratively towards the resolution of shared problems.

That is starting to change. Major inquiries, such as that at Mid Staffordshire in 2013, have caused regulators to look up from ploughing their individual furrows and think about how they collaborate with others in the health landscape. The availability of better data will increasingly make inter-regulator cooperation more fruitful. For example, the data from our annual national training survey now inform the work of a range of other bodies, including the Care Quality Commission (CQC) in England, and we have information protocols in place with a number of organisations.

### Improved data and intelligence sharing

Improved data sharing and intelligence will help regulators target their activities more effectively. It should also mean that the demands on individual doctors and the wider healthcare system to provide the same or similar data for multiple agencies can be reduced because data can be collected once and used for multiple purposes. An example of where this is starting to happen is a project involving the GMC, the CQC and NHS England that aims to map the demands we individually and collectively place on GPs in England in order to remove duplication and streamline our requirements.

These are encouraging developments, but the aspiration should be for regulators and others to go beyond data sharing and work towards a more shared understanding of the problems facing individuals and the systems within which they work, and to find collaborative solutions to those problems. This acknowledges that where individual professionals are struggling it may well be a manifestation of wider pressures within the environment where they are practising.

But in a complex healthcare landscape, an organisation acting alone is often unable to effect the changes needed and is better able to exert influence by working in collaboration with others. We saw an example of this recently in relation to events at North Middlesex University Hospital NHS Trust where the GMC, the CQC, Health Education England (HEE) and NHS England have jointly worked with the trust to address longstanding systemic issues affecting both education and service within the A&E department. We are still learning the lessons from these events, but this sort of collaborative working should provide the template for collective assurance in the future.

## Accessibility of regulation

The availability of better data also means that regulation can become more accessible to the public. The medical register was first published in 1859. Although it is now online rather than a physical book, the sort of information it contains has not changed significantly from what we were providing in the 19th century. It gives little more than a registrant's name and qualifications. It says nothing about an individual's medical practice. But today there is a much greater need (and demand) for information about health professionals and an expectation of openness. Knowing whether or not someone is a doctor may still be necessary but it is no longer enough to help users make decisions about who to trust with their care or who to employ or contract with. If the medical register is to remain relevant and useful, it must evolve to meet the changing needs of those who use it.

These calls for greater openness give rise to concerns about the privacy and safety of health professionals if more information about them is in the public domain, and challenges over what is legitimate for a regulator to collect and record. Such concerns are understandable and must be addressed if we are to develop the register and maximise the potential value of this unique database of every doctor licensed to practise in the UK. All of these issues are explored in our recent public consultation on the development of the register.[75]

## Four country working

Part of the value of UK-wide regulation is in the way the application of common standards and a single register across the UK facilitates professional and patient mobility. But as health systems across the four countries of the UK have begun to diverge with the devolution of political power, the challenge for UK regulation has been to remain relevant and responsive to the changing needs of local populations.

The existence of GMC offices in Scotland, Wales and Northern Ireland has helped us better understand the different contexts in which we operate and forge working relationships with key organisations and individuals. But our expectation is that we will need to go further. Initiatives such as medical credentialing[77] would enable us to support the development of standards in particular fields of medical practice to meet local needs (for example, through the recognition of doctors trained and experienced in remote and rural medicine). Alongside this, we will also want to strengthen our accountability to the legislatures across the UK rather than simply to the UK parliament as at present.

This need for responsiveness to the local context is not confined to the way we regulate in Scotland, Wales and Northern Ireland. The devolution of powers to different health economies within England (as already seen in Manchester) may point to the need in future for a more regional regulatory approach even within England.

However, our ability to maximise the potential of four country (and regional) working takes us back to the issue of data and intelligence. As a recent report by the Organisation for Economic Co-operation and Development highlighted,[77] there is a need for more reporting of data at a country or regional level (rather than a UK level) to support assurance and improvement.

There is also the wider question of how the decision to leave the EU will affect the way we regulate not only for the UK as whole, but also within the devolved administrations. In Northern Ireland, for example, there are likely to be particular issues relating to professional mobility across the border with the Republic of Ireland. We do not know how negotiations between the UK government and the EU will play out, but we will wish to be satisfied that the UK's need for continuing professional mobility is balanced with a requirement that doctors entering the UK are capable of meeting the standards that we set for good medical practice.

## The future shape of regulation

Although the UK government has repeatedly stated its commitment to fundamental reform of professional regulation, its decision in December 2015 not to proceed with the reform proposals brought forward by the Law Commissions in 2014 has been a severe setback and a missed opportunity. If regulators are to meet the expectations of governments and society, they need the autonomy and operational flexibility to respond to changing needs. Too often we find that our efforts to reform and achieve efficiencies are hamstrung by restrictive and outdated legislation that was designed for a different era.

The UK government's latest initiative to examine the future of professional regulation is therefore welcome. It promises to consider the purpose of regulation, alongside issues of autonomy, efficiency and cost-effectiveness. Linked to this is an expectation that the current configuration of nine professional regulators will change. We anticipate that some regulators may merge and others be abolished. Questions will be raised about whether it is proportionate for some professions to continue to be regulated and whether the public interest requires that others should be and, if so, by whom.

Although medical regulation has existed for over 160 years, and we have an increasingly strong track record of effective, independent regulation, we do not imagine that we can stand apart from these debates. Indeed, our aim will be to seek a future configuration of professional regulation that will best deliver protection for patients and the public and support high standards of professional practice. It remains to be seen whether the current government will turn the rhetoric into action.

# 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 comparative differences are reported in the text, these are large enough to be robust to the occasional proportional changes that have previously been observed in our data due to on-going GMC processes.

Percentages in all tables are rounded and may not add up to 100%.

Data for the analysis of the profession in 2015 refer to the medical register (known as the List of Registered Medical Practitioners), the GP Register and the Specialist Register on 31 December 2015. Data for the analysis of the change between 2011 and 2015 refer to the state of the registers on 31 December of each year between 2011 and 2015. Where data are aggregated over 2011–15, 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 excluded unless stated otherwise.

## Fitness to practise data

Fitness to practise data for 2011–15 was for enquiries either received or closed between 1 January 2011 and 31 December 2015. The data were drawn from the GMC's database on 7 July 2016. 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 at the point of a decision being made – either the case examiner giving a decision, or the Medical Practitioner Tribunal Service hearing ending. 36% of complaints that originated in 2015 and were investigated did not yet have an outcome (800 complaints) when the data were drawn from the GMC database.

## Data on medical students and doctors in training

Data about medical students by academic year between 2011 and 2015 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 2016 national training survey – it was accurate on 22 March 2016. 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 2016 national training survey was open from 22 March to 4 May 2016. Doctors in training were asked about the post they were in on 22 March 2016. 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 – 166 doctors were in this group in 2015.

## Data relating to the age of a doctor

There is a small group of doctors on the register with no date of birth recorded (2.0% in 2011 and 1.4% in 2015). 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 18% of licensed doctors on the register in 2015.

## Regional and country data

The index of doctors per population given in chapter 5 figure 48 was derived using a denominator based on mid-2015 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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