General
Medical
Council

The state of medical education and practice in the UK

2017

Working with doctors Working for patients

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Contents

Foreword

Our seventh 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 data relating to the changing medical register and explores the patterns of complaints about different groups of doctors.

Health professionals across the UK – and doctors in particular – continue to provide exceptional care to patients. Despite increasing workloads, staff shortages, financial pressures, a series of terrorist attacks, and, of course, the uncertainty of Brexit. Once more they have risen to the challenge and demonstrated their professionalism.

While we can admire their achievements and pay tribute to their dedication to serving the public, we cannot let this distract us from the fact that their good will and commitment to always go the extra mile – are what keep our health services running.

This level of sacrifice is neither right nor sustainable, and there are clear warning signs within our report that some doctors are being pushed beyond the limit.

These pressures may be one reason why it is becoming increasingly common for doctors to take a break from formal training after they complete the foundation programme.[1] Some do this because they want greater work-life balance, some for overseas training experiences. Others report feeling burnt out after just two years as a newly qualified doctor.

There are plans in motion to address these issues – an increase in medical school places in England, the growth of medical associate roles, and drives to boost overseas recruitment. These schemes and others should ease some of the pressure felt by doctors. However, while we welcome these initiatives and will support them all we can, their impact will not register for some time and there are questions about whether they are enough to meet the challenges we can see ahead.

We have reached a crucial moment – a crunch point – in the development of the UK's medical workforce. The decisions that we make about it in the next five years will determine how well doctors can meet the far greater demands expected at the end of the next two decades, when the UK's population is projected to be larger and older.

We are a professional regulator, not a workforce planning body. However, we want to be an active partner in helping each nation of the UK to have the right number of doctors with the right skills in the right place for patients – through our leadership in the healthcare system; the critical role that we play in doctors' education, training and development; and the data and insights we can share with those responsible for workforce planning. This is why we have identified in the Overview the warning signs in relation to our medical workforce and the priorities we have for workforce training and planning.

We also want to strengthen our support for doctors, helping the profession with the challenges they face either on the wards or in the community – lending a hand where it matters, stepping in early to stop a concern becoming worse and lightening our touch wherever possible to maximise the time doctors spend with patients.

In the past we have focused our efforts on taking action after some act of harm has been caused or where training environments have struggled to provide the training and education our doctors deserve. Now we want to invest more of our energy and resources in supporting good practice to prevent such harm or training problems from happening in the first place. This may take some years but we believe this approach is better for patients, doctors and employers.

We have already started to shift our approach. To make more progress, we need the UK Government to change the law.

As it stands our current legal framework, laid out in the Medical Act, is too prescriptive[2] and not fit for 21st century healthcare. We have worked within the constraints of this to reduce the number of full fitness to practise investigations we carry out (such as those involving one-off clinical mistakes) and act as proportionately as possible. But we know many of our processes remain slow, inflexible and heavy-handed. Yes, we have modernised and we will continue to make improvements where we can. However, the law is a roadblock stopping us from making some changes that would make a real difference to doctors and patients.

What we need is legislation that allows us to be swift and agile in carrying out our primary duty – keeping patients safe – while reducing the stress and burden on doctors and the wider healthcare systems. Reforming the law will let us concentrate our efforts on supporting good medical practice, while using our data about the profession and the environments in which doctors practise and train to act when we can see risks emerging to them and to patients.

To their credit all four Governments of the UK and all political parties have agreed that change is necessary and we welcome the current consultation[3] on the future of professional regulation. Once that consultation closes early next year, we need the UK Government to turn its promise of reform into action and bring forward legislation that is fit for purpose as quickly as possible.

Professor Terence Stephenson
Chair of Council

Charlie Massey
Chief Executive and Registrar

Overview

In our 2016 report we highlighted the 'state of unease' gripping the UK's medical profession.[4] This was the first time we had expressed such a serious concern about the pressure on doctors and the effect this was having on their morale and wellbeing.

Part I: Four warning signs

From what doctors tell us – through their feedback, behaviour and choices – it is clear that this 'unease' has continued through 2017. Rich as this report is with data and insights, four trends stand out in particular and it is crucial we bring these 'warning signs' to the attention of governments and national agencies, and other bodies responsible for training and workforce planning:

A The supply of new doctors into the UK medical workforce has not kept pace with changes in demand

B Our dependence on non-UK qualified doctors has increased in some specialties

C The UK is at risk of becoming a less attractive place for overseas doctors to work – both to those already in the UK and those outside it

D The strain on doctors training and being trained continues.

We need to pay attention to these signals that doctors are sending us. Keeping the good doctors that we have – and attracting the doctors of tomorrow, wherever they may come from – means bodies like us working much harder to make medicine feel more like a worthwhile, sustainable and rewarding career.

All of us in healthcare must value doctors, and protect and support them much better than we do now – this must be at the centre of any country's workforce strategy.

A The supply of new doctors into the UK medical workforce has not kept pace with changes in demand

The number of doctors taking up (or returning to) a licence to practise has remained relatively steady between 2012 and 2017 – an average of around 13,000 doctors are entering UK practice every year.

This figure must be seen in the context of rising demand on health services across the UK. In England there was a 28% increase in accident and emergency (A&E) attendances between 2012–13 and 2016–17,[5, 6] while Northern Ireland saw a 11% increase over that same period.[7, 8] An analysis by The King's Fund published in May 2016 found the workload of GPs has grown both in volume and complexity, with a sample showing a 15% increase in the number of consultations from 2010–11, and 2014–15.[9]

This absence of growth in the supply of doctors is a worry given the demands experienced by doctors now and how they are projected to rise in the future as the UK population continues to

change. Between 2012 and 2016 there was a 5.4% drop in the number of medical students attending UK universities* and the number of doctors in postgraduate training only increased by 1.7%.

In 2012 it was said that people with long-term conditions accounted for about 50 per cent of all GP appointments, 64 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days.[10] Long-term conditions are more prevalent in older people and in more deprived groups. Some people living in a deprived area will have multiple health problems up to 15 years earlier than people in affluent areas.[11]

Over the next two decades the total number of people aged 65 and over is estimated to grow by nearly 50%, which amounts to around 6 million people. In keeping with current trends, the fastest growing group will be those aged 85 years and over with the numbers projected to double, from 1.6 million people to 3.2 million in 2041.[12]

Although the needs of these patients will be met not just by doctors but by a range of health professionals working closely together, the medical profession will undoubtedly need to grow to meet this extra demand. Twenty years may seem like a long time but not when you consider how long it takes for a doctor to complete their university education and, if they choose to become a consultant or GP, their subsequent postgraduate training.

Where the profession needs to grow – in terms of both geography and expertise – is the crucial issue. The prevalence of long-term conditions varies hugely across the countries and regions of the UK. More work needs to be done by workforce planners in partnership with those commissioning medical education to identify which types of doctors (such as GPs, psychiatrists, and other specialists in long-term conditions) will face even greater demands in the future and where those doctors are best located (bearing in mind that where a doctor studies and trains can have an influence on where they will stay practising for the rest of their career).

The best location may not be within towns and cities. The population in rural areas has a higher proportion of older people compared with urban areas,[13] plus there are projections that depression, stroke, falls and dementia could grow by between 50 per cent and 60 per cent in rural areas, compared to increases of between 34 per cent and 42 per cent in urban areas.[14] Currently skilled medical professionals are particularly scarce in these parts of the UK and these gaps can be hard to fill with new doctors. The remote nature of these areas can make them unattractive places to work and train.

In 2016 Cumbria had more than 50 vacancies in a consultant workforce of over 200, with critical shortages in acute medicine, paediatrics and other key specialties.[15] In February it was reported that Lincolnshire had a shortage of GPs that was leaving some rural patients waiting four weeks to see their doctor.[16]

The knock-on effect of these shortages is that locums are increasingly being used, especially in deprived areas.[17] For example in 2015 NHS

* The reasons for this change include the cumulative impacts of a 2% reduction by the Department of Health in the number of medical student places in England introduced in 2013 and clarification of how the proportion of places allocated to non-EEA overseas students should be calculated.

Bradford City, the most deprived Clinical Commissioning Group (CCG) area in England, had the second highest use of locum doctors, at 18%.[18] The increasing reliance on the use of locums has risks, and the British Medical Association (BMA) has warned that this lack of continuity is not good for patients.[17]

General practice is one of several specialties that have rightly been earmarked as a national priority for recruitment.[19] Between 2012 and 2017 our data tell us there has been a 3% increase in the number of doctors on the GP register – below the 4% increase in the overall UK population in that period. This is significantly below the increase in people aged 65 years and over that was experienced by each UK country between mid-2011 and mid-2016 (ranging from 11.4% and 13.2%).[12]

Psychiatry is another specialty requiring attention.[19] Around one in four people in the UK will experience a mental health problem each year and the prevalence of these conditions appears to be increasing.[20] In May 2017 a survey published by the Office of National Statistics (ONS) found 22% reported a mental health impairment in 2015–16 up from 18% in 2013–14.[21]

As our report shows, between 2012 and 2017 there have been increases in the number of specialists working in emergency medicine, (+25%), obstetrics and gynaecology (+8%), paediatrics (+16%), and radiology (+9%). Unfortunately, the same cannot be said for psychiatry where the number of consultants fell by 1%. At postgraduate level the number of doctors training in psychiatry has shrunk by 9%.

B Our dependence on non-UK qualified doctors has increased in some specialties

The UK relies on doctors from overseas to deliver a substantial amount of patient care. Their contribution is vital and the diversity of experience they bring to the medical workforce is hugely welcome.

This dependence varies from specialty to specialty and from region to region. Our data show that 18% of licensed doctors in the South West of England are non-UK graduates compared with 43% in the East of England, 41% in the West Midlands and 38% in the East Midlands. Northern Ireland is the country with the smallest proportion of licensed doctors with a non-UK primary medical qualification (PMQ) (14%).

Although the proportion of UK graduates on the medical register increased from 63% to 67% between 2012 and 2017, there are specialties that continue to be reliant on non-UK graduates.

Emergency medicine, medicine, and paediatrics have seen increases of more than 20% in the number of non-UK qualified doctors between 2012 and 2017 – increases mainly driven by overseas recruitment drives.

The specialties with the highest reliance on non-UK graduates are obstetrics and gynaecology (55%), ophthalmology (48%), and paediatrics (46%), while psychiatry and pathology have more than 40% of their doctors drawn from this cohort.

International recruitment will always be a feature of workforce planning, and it is important that we create opportunities where doctors and health professionals from other countries can share in the learning experiences which our health services have to offer. The question is whether our reliance,

established over many years, should be reduced in favour of a more strategic and sustainable approach. In April 2017 the House of Lords select committee on the Long-term Sustainability of the NHS and Adult Social Care said there was 'too much reliance on overseas recruitment' and it called on the Government to 'outline its strategy for ensuring that a greater proportion of the health and social care workforce comes from the domestic labour market' in the future.[22]

C The UK is at risk of becoming a less attractive place for overseas doctors to work – both to those already in the UK and those outside it

The increased dependency of some medical specialties on non-UK graduates may make it appear like the UK continues to be an attractive place for doctors to work. However, our registration data suggest that its appeal may be in danger of decline.

Between 2012 and 2017 the number of licensed doctors who were UK graduates increased by more than 10,700. However, this growth was offset by a reduction in EEA graduates and international graduates. In 2017 there were 6,000 fewer non-UK graduates on the register compared to six years ago.

South Asia (which includes the countries of India and Pakistan) has been the largest source of international graduates for the UK historically and accounts for nearly half of the fall in the number of these doctors (down by 2,500). Meanwhile we have seen the number of licensed doctors from Oceania (which includes Australia and New Zealand) fall from 1,980 in 2012 to 1,252 in 2017 (a drop of 37%). EEA graduates have fallen by more than 1,300 (a drop of 5.9%).

It is hard to say what is causing this effect across such a diverse range of countries. The economic conditions in some of these countries (such as the recent growth of the Indian economy and gradual end of the global economic slowdown) could have made emigration to the UK less attractive than previously. Of course Brexit may also be a factor. We know that the introduction of revalidation in 2012 led some doctors, particularly those based outside the UK, to relinquish their licence to practise because they were unable to maintain a connection to a designated body in one of the four countries.

In November 2017 the ONS published migration figures for the first full year since the UK voted to leave the EU.[23] In the year to June 2017, there were 230,000 more people coming to live in the UK than leaving the UK to live abroad – what is called 'net migration'. However, that net figure was 106,000 lower than the year before and over three quarters of the fall was due to EU citizens. Although the ONS said the decline followed historically high levels of immigration and it was too early to say whether this represented a long-term trend, it suggested that Brexit is likely to be a factor in people's decisions to move to or from the UK.

In February 2017 we carried out a survey of EEA doctors practising in the UK to establish a snapshot of their future intentions following the EU referendum.[24] A little over 2,100 doctors responded to our survey, with 1,280 (61%) saying they were considering leaving the UK at some point in the future. Of these 1,280 doctors, more than 90% said the UK's decision to leave Europe was a factor in their thinking. Worrying as these findings are, they reflect other data we hold which show EEA graduates are a highly mobile workforce. Even before the referendum, 14% to 16% of licensed EEA doctors relinquished their

licence each year between 2014 and 2016.[25] That said, given the reliance that some specialties continue to have on non-UK graduates and the many years we have to wait before we see the benefits of the increased number of medical school places announced by the Government in England, a sudden increase in EEA doctors leaving the UK would put health services and the medical profession under even greater strain. We must continue to keep a close watch on these numbers, alerting employers if we see a significant change.

D The strain on doctors training and being trained continues

Our best source of data exposing the pressure on doctors is our national training surveys – run every year between March and May, and now covering nearly 80,000 doctors across the four countries of the UK.[26]

Around a fifth of doctors in training said they felt short of sleep while working. Just over 40% rated the intensity of their work during the day as 'heavy' or 'very heavy'. This figure is higher for doctors training in emergency medicine (over 70%).[27]

The pressure on trainers (normally senior doctors) is similar. 70% of trainers felt their daytime workload was 'heavy' or 'very heavy' – a situation we will continue to monitor.[28]

We are concerned by this pressure for three reasons: first, the impact it may be having on doctors' physical and mental wellbeing; second, the impact it may be having on the quality of doctors' training experiences; and third, the impact it may be having on the quality and safety of patient care. Almost a third of trainers felt their job plans did not contain enough dedicated time for their role as an educator. In new questions which we tested this year to understand the quality of rota design, around a third of doctors in training told us that rota gaps have an impact on their training opportunities.[28]

The strong links that exist between our four country liaison services and doctors on the ground add to our understanding of the pressures they face and give us greater insight into these difficulties.

Between November 2016 and February 2017, our Employer Liaison Service gathered feedback from 153 responsible officers,* covering over 200 healthcare organisations throughout the UK, to explore their perceptions of the current state of morale across the medical profession and the key factors contributing to it. More than 80% told us they felt morale was declining. Interestingly, those outside of England and those in the independent sector reported a lower reduction in morale. These differences may reflect longer-term impacts from the contract dispute in 2016.

It is not surprising that, in the face of these workload pressures, doctors are finding ways to achieve more balance between their professional and personal lives. It is becoming more common for doctors to take a break after they finish foundation training.[1] The proportion doing this has increased between 2012 and 2016 – from 30% to 54%.[29]

Most return to postgraduate training but some do not. In our 2017 national training surveys, 17% of F2 doctors said they aimed to take an immediate break from training. The reasons they gave included achieving a better work-life balance (86%), gaining further experience before making a decision about what they should do next (60%), and suffering from burnout (51%).[27]

* This sample size provides a statistically valid response rate for the population of responsible officers which is c.600 covering c.900 designated bodies.

Part II: Four priorities for workforce planning

In light of these warning signs, we want to highlight four priorities for governments and national agencies, and other bodies responsible for training and workforce planning in the UK. This is to help them ensure there is a medical workforce in each country that has the right size, strength and capability to respond effectively to the demands placed on their health services now as well as in the future.

We set out the contributions that we can make to these priorities as a professional regulator. The crucial role that we play in doctors' education, training and development - together with the wealth of data and insights that we can share with those responsible for workforce planning - mean that we can be an active partner in this work. Together, we must:

1 **Maintain a healthy supply of good doctors into UK practice**

2 **Help the UK medical profession to evolve to meet the future needs of patients and healthcare**

3 **Reduce the pressure and burden on doctors wherever possible**

4 **Improve the culture of the workplace, making employment and training more supportive and flexible.**

1 We must maintain a healthy supply of good doctors into UK practice

There is more uncertainty than ever around how the health services across the UK will meet the challenges they face. It is difficult to predict what effect Brexit will have on services already struggling to meet the demands of an ageing population with more complex healthcare needs.

Although the proportion of UK qualified doctors in the medical workforce has increased, there is still a reliance on doctors from abroad. Given the uncertainty that we face over the next few years and the concern we have highlighted that the UK is in danger of becoming a less attractive place for overseas doctors to work, serious thought must be given by workforce planners as to where the doctors in the short and medium-term future will come from and whether this 'reliance' is sustainable.

In August 2017 the Department of Health confirmed that it would increase the number of medical school places in England.[30] From September 2018 the number of places will increase by up to a quarter. The scheme aims to make the NHS 'self-sufficient' in doctors. However, the effect of these extra doctors (500 a year rising to 1,500) will only be felt from the summer of 2023 onwards and, as this report shows, the number of medical students with UK nationality attending UK universities has decreased by more than 2,300 between 2012 and 2016. We therefore welcome the proposal by HEE to start a conversation about the need for any further expansion of doctors graduating in 2026 and beyond.[31]

However, an increase in medical students will lead to an increase in doctors in postgraduate training and the impact on trainers, some of whom are clearly struggling to cope with their current education responsibilities, must be considered. We must recruit a sufficient number of trainers to match this future demand.

In the meantime, before these extra doctors enter the medical workforce, we must take care not to lose any of the doctors who are practising in the UK right now. We note the joint report[32] from the EU withdrawal negotiations published in early December 2017 by the UK government and the European Commission, and we welcome the ongoing progress which recognises the importance of providing certainty to the thousands of EEA qualified doctors who play such a vital role in the UK's healthcare systems. We must also make sure that international recruitment efforts, such as the one launched in 2017 by NHS England to boost GP numbers, succeed. It is important, though, that these efforts are carried out in an ethical way to avoid damaging health economies of other nations, particularly those that are developing.

One solution, which we support, is to expand the Medical Training Initiative (MTI) sponsored by the Academy of Medical Royal Colleges, which allows doctors from outside the EU to enter the UK on a time-limited basis.[33] The scheme, which started in 2009, lets doctors benefit from training and development in NHS services before returning to their home countries after two years. The doctors involved are issued with a type of visa which enables exchanges or educational initiatives sponsored by a government department.

The GMC controls the gateway into UK practice. The checks that we carry out are important because they make sure that doctors, regardless of where they studied in the world, are qualified and safe to practise here. These checks must be robust – patients, employers and other health professionals would not be confident in the doctors granted entry to the medical register without them. However, we believe there are ways we can make our checks and procedures more flexible and streamlined.

At present doctors enter UK practice through a variety of routes. Around 60% of international medical graduates take our Professional and Linguistic Assessment Board (PLAB) test, while under current legislation doctors from the EU can secure a UK licence to practise without any test of their competence. The UK's 32 medical schools have their own methods of assessing whether their students meet our Outcomes for graduates. This lack of consistency and assurance to patients is why we want to introduce a Medical Licensing Assessment. We have recently agreed the model for the MLA following a public consultation earlier this year and in 2018 we will begin to develop the elements of the assessment in more detail.

One barrier after joining the register is the transition into UK practice. This is hard for any doctor but especially for one who has qualified outside the UK and may be unfamiliar with our culture of healthcare. Our *Welcome to UK practice* programme helps these doctors by providing a free, half-day workshop that guides them through the ethical issues they will face in their practice.[34]

How we will help

- We will support the expansion of undergraduate education by completing our quality checks on several universities wanting to offer medical degrees. We have liaised closely with the Higher Education Funding Council for England (HEFCE) and HEE as they have developed their plans for expanding the

number of places, including providing them with data to support decisions on the allocation of new medical school places.

- We will continue to support NHS England's drive to increase international recruitment of GPs. We have also been working with the Royal College of General Practitioners (RCGP) to map its curricula against that of the Australian system to study its equivalence.

- Doctors from outside the UK need to prove they can use English to a safe standard before we grant them a licence to practise. They can already do this in several ways. In 2018 we will explore how we can make our arrangements even more flexible while maintaining the high standards we expect doctors to meet.

- We are increasing our capacity to deliver our PLAB test to international medical graduates both in the UK and overseas. We now run the knowledge part of the assessment from two centres in the UK (London and Manchester) and this year we have added three overseas venues (Canada, Australia and Ghana) due to high demand from applicants in those countries – bringing the total number of overseas venues to 19. In 2018 we'll double the number of dates for the clinical part of the assessment compared to 2016.

- The outcome of Brexit is hard to predict although it is possible that once we leave the EU we'll have to assess doctors who qualified in those countries the same way as international medical graduates - by requiring them to take our PLAB test (which in due course will become our Medical Licensing Assessment – MLA). This could have a huge impact on our registration operations but more importantly on the speed with which the NHS can get these doctors onto the front line. Next year we will start to develop plans for this eventuality, to make sure we have the extra capacity in place right when we and employers need it. We also need changes to our legislation to let us streamline how we assess senior doctors from other countries. We will work with the Government to explain the changes required to ensure that we can take more control of the way doctors can enter our Specialist or GP Registers.

- We will continue to publish data about EEA doctors practising in the UK to provide up-to-date information and assurance for employers. For the first time we'll also publish country-level workforce reports to aid the four governments of the UK and their agencies with national planning. In spring 2018 we will launch a new tool on our website that will give open access to our registration data as it changes to real-time.

- We will expand our successful *Welcome to UK practice* programme for doctors. The programme reaches around 28% of doctors who are new to UK practice at present, and during 2018 we will begin to open up this programme to thousands of doctors every year.

2 We must help the UK medical profession to evolve to meet the future needs of patients and healthcare

Older patients, of which there will be many more in the future, require more care and have a greater need for integrated services that are designed around them.[35] Of particular concern for doctors is the fact that older patients are more likely to exhibit multi-morbidity – experiencing two or more conditions that require medical attention at the same time. By 2025 the RCGP estimates that 9.1m people in the UK will have one or more serious long-term conditions, at an additional cost to our health services of £1.2bn each year over the next decade.[36]

Analysis in the Lancet of growing multi-morbidity in patients identified a need for generalist skills,[11] echoed by the RCGP and the Health Foundation, especially in community settings and within training.[37] We need doctors who can offer a broad range of skills within their specialisms, as well as doctors whose expertise covers more than just their specialism. We will see specialists having to be more involved in community care and coordinating with GPs to ensure that care is delivered in the appropriate setting. There needs to be more work done to identify which specialisms will be required in the future and where those specialists are best placed.

Increasingly the aspiration is that care will be delivered in the home environment in an integrated way working with a more patient-led approach, where doctors support patients in self-managing their chronic conditions. Health promotion is likely to play an even larger role in healthcare, nudging the population to adopt healthier lifestyles. The same goes for technology, with remote monitoring of patients becoming more frequent.

The Secretary of State for Health recently announced an independent review, led by Professor Eric Topol, to provide advice on how technological and other developments (such as genomics, pharmaceutical advances, artificial intelligence, digital and robotics) are likely to change the roles and functions of clinical staff in all professions over the next two decades. We welcome this review and look forward to contributing to it.[31]

We have a role to play in supporting doctors to adapt to these types of changes while ensuring patient safety. The growth of other healthcare workers in areas traditionally reserved for doctors, such as increased roles for nurses or the increasing number of medical associate professions, will necessitate greater co-ordination and the sharing of expertise between regulators.

How we will help

- In the spring 2017 we published our review of postgraduate training[38] that highlighted real problems in the way doctors' training is organised. A key finding of our report was that many of the specialties and sub-specialties develop their training requirements in isolation from another. Since publishing our review we have been working with the medical colleges and faculties to transform their postgraduate curricula, to help give doctors the professional capabilities they need to work flexibly and confidently across a range of care boundaries and locations. By 2020 these curricula will include the high level learning outcomes with some sharing content. This year we have approved updated curricula for paediatrics and internal medicine.

- We are carrying out similar transformational work at undergraduate level. This year we launched a consultation on our outcomes for graduates[39] – the knowledge, skills and behaviours which medical students need to display by the time they leave medical school. We've included new, forward-looking outcomes in key areas such as population health and genomics – to make sure our graduates are prepared for tomorrow's world.[40] In 2018 we'll complete work on these outcomes and roll them out to UK medical schools so they can begin to adapt their curricula for students.

- Revalidation was introduced five years ago, in 2012, as a lever to help doctors to stay up to date and fit to practise, encouraging reflection and professional development. In 2018 we will be working with medical bodies and employers to improve the quality of the appraisal experience for doctors. This will be another way to enable the profession to evolve and re-skill to meet changing patient needs.

- Towards the end of 2017 the UK Government launched a consultation[3] seeking views on whether four medical associate professions should be subject to statutory regulation. Medical associate practitioners (MAPs) work closely with doctors and their work is aligned to the medical model. We have said that bringing these roles into regulation would help them grow and mean that we maximise the contribution that these professionals can make to doctors and wider healthcare services. However, we also strongly feel MAPs should be considered as a single umbrella profession made up of four areas of practice. This would future-proof the profession, enabling the development of roles in other areas of practice. We expect the Government will make a decision early next year on which regulator – the GMC or the Health and Care Professions Council (HCPC) – should take responsibility for these roles. We have responded to this consultation to say that we would be prepared to regulate them subject to certain conditions being met.

3 We must reduce the pressure and burden on doctors wherever possible

In this challenging environment – where doctors' time and attention are a precious resource – we need to be extremely careful about the impact which we have as a professional regulator.

Regulation has clear public value but there are aspects of how we work that create a level of burden on doctors, that is unhelpful and unnecessary given the strain they are under. We are committed to reducing this burden wherever we can.

This pressure comes in many forms. One area where we have recently taken action is our registration fees. We have kept these as low as possible in recent years. However, we are conscious that the cost of maintaining registration is one of a number of fees that a doctor must pay to stay in practice.

Revalidation is working, with many doctors saying they have improved their practice as a result. However, now that the nuts and bolts are in place, we need to make the process of preparing for appraisal a more straightforward experience for doctors, as well as encourage the quality of appraisals locally to improve. As an independent review by Sir Keith Pearson found earlier this year, poor IT systems locally can make it hard for doctors to collect their supporting information. There also appears to be some confusion locally about our requirements. Solving this challenge, one we share with medical colleges and employers, is firmly in our sights.

Being investigated by the GMC can be a hugely stressful experience for a doctor and we are doing what we can to minimise this by changing how we work. The introduction of our provisional enquiry process – where we gather a limited amount of information at the point we receive a complaint – has avoided the need for around 700 full investigations.

We have also introduced a new dedicated team that works with doctors who have health concerns that may have an impact on their ability to provide safe care to patients. This follows our work with Professor Louis Appleby. This team lets us be more sensitive to the health needs of these doctors. In some cases, they can pause our processes to let the doctor seek treatment.

How we will help

- In December 2017 we announced that all doctors will receive a fee reduction of £35 from April 2018 and that we will introduce a substantial fixed-term discount for UK doctors during their first six years on the register, saving them over £1,000.
- In March 2018 we will publish updated guidance for doctors on collecting supporting information for their appraisal and revalidation. This will make it clear to doctors what is – and importantly, what is not – a requirement for revalidation. We'll work with employers and medical colleges to ensure there is the necessary clarity locally among responsible officers, appraisers and doctors.
- We will continue to find ways to streamline our fitness to practise investigations, lessening their impact on doctors and complainants where we can. The number of concerns raised with us by doctors' employers has fallen each year since 2013 and particularly sharply in 2016 (down by 35% from 2015). This may reflect the positive impact of responsible officers who are helping to resolve and prevent more issues locally, supported by our Employer Liaison Service. In

2018, driven by our new corporate strategy, we will look at whether some of the concerns currently raised with us would be more appropriately and proportionately handled first, locally, by employers.

4 We must improve the culture of the workplace, making employment and training more supportive and flexible

Our data and wider research about the profession tell us that the demands on health services continue to affect doctors' workloads, training and wellbeing.

In January 2017 a new scheme was launched by NHS England to provide confidential health advice to GPs and GP doctors in training in the country.[41] In June it was reported that the service had received 400 referrals in the five preceding months. That same month a BMA survey found more than half of salaried and locum GPs suffer from stress as a result of their work, with one in ten taking time off because of work-related stress.[42]

This pressure on doctors begins early. As mentioned earlier in this chapter, our 2017 national training surveys reveal that 17% of foundation year 2 doctors want to take an immediate break from training. Achieving a better work-life balance and burnout were among the main reasons given.

In the face of this pressure – but also because of wider changes in our society – it's no wonder that more doctors are choosing to take a break after the foundation programme, that some are choosing to work differently to have more control over their hours – as locums, for example – and that many are opting to work or train less than full-time.

We can see the increased popularity of these ways of working in our national training surveys data.[27] In 2017 9% of doctors at postgraduate level reported they were training on a less than full-time basis – compared with 7% in 2012. In general practice, the proportion of doctors training less than full time has increased from 10% to 17% between 2012 and 2017. The demand for less than full-time training could be even higher than these figures suggest, and careful thought needs to be given to how training programmes and the health services through which they are delivered cater for this demand in the future. In a survey of more than 6,000 doctors in training that we ran earlier in 2017, 56% said they were considering less than full-time training arrangements.

As a professional regulator we have no influence over the level of demand faced by doctors and other health professionals, nor do we have any say over the resources which are put in place to deal with that demand. However, we can play a role in driving better cultures within the workplace.

The standards and requirements that we set for doctors' education and training make it clear that organisations must demonstrate a culture that allows everyone, both learners and educators, to raise concerns about patient safety, care standards or the quality of education openly, safely and without fear of adverse consequences.

When there are education concerns it is vital that we act in partnership with others to address them quickly before they get worse and cause real harm to doctors in training or patients. Our legislative powers give us the ability to take action against a provider. In extreme cases, in order to protect doctors and patients, we can remove our approval for an organisation to provide particular programmes of training.

In 2018 we will be actively considering the ways in which we can become more effective in this critical area of our work. This will include strengthening our understanding of organisations that find themselves in difficulty because of the impact their environments can have – on the education and training of doctors; on a doctor's ability to meet our professional standards; and on the morale, mental health and wellbeing of doctors and other professionals. Knowing the root causes and underlying characteristics of these environments that are in these positions could enable us to predict and intervene in problems at an earlier stage.

Learning and development are top drivers of employee satisfaction in any industry and play a major role in defining the health of an organisation's culture. In our 2017 national training surveys almost a third of trainers felt their job plan did not contain enough dedicated time for their role as an educator, and around a third of doctors in training told us that poorly designed rotas have an impact on their training opportunities.

The time doctors have to train and be trained must be planned and protected, and we have called on employers to consider how they can do this better. This investment in doctors' professionalism and development will lead to improvements in patient care. We see revalidation playing an important role in this cultural change. Its introduction five years ago, in 2012, has driven up appraisal rates and, with the help of colleague and patient feedback, is encouraging a greater degree of reflective practice among doctors. Our challenge, as mentioned, is to work with employers and their teams of appraisers so that every doctor has an appraisal that is worth their time.

How we will help

- We will continue to use our national training surveys to monitor the impact of service pressures, taking action in partnership with others to tackle education concerns affecting the quality of training and the wellbeing of doctors. In recent years we have done this at places such as East Kent Hospitals University NHS Foundation Trust and North Middlesex University Hospital NHS Trust. In 2018 we will start reporting rota data about individual education providers.
- We will continue to encourage doctors training in England to report concerns about their education, through the new exception reporting system[43] managed locally by guardians of safe working hours. Some doctors in training have told us they have experienced pressure not to report their concerns, which we find worrying as this culture is clearly not compatible with the standards we expect from education providers. During 2018 we should begin to receive annual reports from guardians and we will use these data, alongside the evidence from our national training surveys, to develop a more forensic understanding of the pressures within training environments. We will support similar reporting initiatives in the other three countries of the UK such as the scheme introduced in Scotland to monitor the working hours of doctors in training.
- In spring 2018 we will publish further qualitative research to help us and others understand how doctors proceed through training and why it's becoming more common for them to take breaks.

- We want to tackle the impact that working in medicine can have on doctors' mental health and wellbeing. Over the last year we have worked with doctors and their representatives to explore how we could sensitively measure their wellbeing in a way they find comfortable. In January 2018 we will test a range of possible new questions on burnout for inclusion in our national training surveys. Also in January 2018 we will bring together experts from around the UK to advise us on where we can best focus our efforts to help the wider profession.
- Our new outcomes for graduates, which we will finalise in 2018 as part of our work to develop a medical licensing assessment, will include a requirement for medical schools to ensure students can incorporate self-care into their personal and professional lives.

Conclusion

Our report identifies an array of challenges facing the medical profession today and it's clear those challenges will become even greater over the next 20 years unless action is taken. The UK population is predicted to grow larger and older requiring more care.

We have reached a crucial moment – a crunch point – in the development of the UK's medical workforce, and attention must be paid to the warning signs that doctors are sending us. The decisions that we make about it in the next five years will determine whether it can meet these extra demands. This requires each country to think carefully about how many doctors we need, what expertise we need them to have so they can work as flexibly as possible for patients, and where they should be located given the changes and movement in population expected.

We are a professional regulator, not a workforce planning body. However, we want to be an active partner in helping each country of the UK to address these priorities.

Keeping the good doctors that we have – and attracting the doctors of tomorrow – means bodies like us working much harder to make medicine feel more like a worthwhile, sustainable and rewarding career. All of us in healthcare must value doctors, protecting and supporting them much better than we do now – this must be at the centre of any country's workforce strategy.

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 2017*. 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/somep2017.

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 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 2012 to 2017. 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.

Data for the analysis of the profession in 2017 refer to the LRMP, the GP Register and the Specialist Register on 30 June 2017. Data for the analysis of the change between 2012 and 2017 refer to the state of the registers on 30 June each year between 2012 and 2017. Where data are aggregated over 2012 to 2017, the unique count of doctors across the snapshots of each years data are used.

2 Register of medical practitioners 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 June of each reported year. 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

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 time of census in 2017. 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 2016/17. 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 about cases are presented for each of the years 2011–16 and for the period 2011–16 while data about doctors are presented for each of the years 2012–16 and for the period 2012–16, 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 2011–16 or 2012–16 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 a third of the tables count the number of particular fitness to practise processes or outcomes, about third count the number of doctors involved in those processes or outcomes, and the remaining third reports the proportions of licensed doctors and doctors involved in different fitness to practise processes or outcomes. The tables cover fitness to practise enquiries, complaints, investigations, and tribunal 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

This is our seventh annual report of the state of medical education and practice in the UK. It sets out an overview of the challenges that feature strongly in healthcare. It presents recent data and analysis that helps our understanding of the current and future medical workforce. It also explores the patterns of complaints about different groups of doctors.

Four warning signs

This year's report comes during a time of ongoing pressures and challenges within the health service. It is clear that the state of 'unease' we reported in 2016 has continued.

Reviewing our data and insights analysis, four trends stand out and it is crucial we bring these 'warning signs' to the attention of governments, national agencies and other bodies responsible for training and workforce planning:

A The supply of new doctors into the UK medical workforce has not kept pace with changes in demand.

B Our dependence on non-UK qualified doctors has increased in some specialties.

C The UK is at risk of becoming a less attractive place for overseas doctors to work – both to those already in the UK and those outside it.

D The strain on doctors training and being trained continues.

We need to pay attention to these signals that doctors are sending us so that we keep the good doctors that we have and attract the doctors of tomorrow wherever they may come from.

Four priorities for workforce planning

In light of these warning signs, we highlight four priorities and set out the contributions that we can make as a professional regulator to these various challenges.

1 We must maintain a healthy supply of good doctors into UK practice

- We will support the expansion of undergraduate education by completing our quality checks on several universities wanting to offer medical degrees.
- We will continue to support the drive to increase international recruitment of GPs.
- Next year we will see if we can make our arrangements for language testing even more flexible while maintaining the high standards we expect doctors to meet.
- We will expand our successful Welcome to UK practice programme for doctors who are new to UK practice and new to the country.
- We are increasing our capacity to deliver our Professional Linguistics Assessment Board (PLAB) test, taken by doctors who are new to UK practice and new to the country.
- We are developing plans for any changes that Brexit brings to make sure we have extra capacity in place, should it be required. This includes preparing for the eventuality of testing doctors from the European Economic Area (EEA) in the same way as international medical graduates. We will work with the Government to explain the changes we need to our legislation, to let us streamline how we assess senior doctors from other countries.
- We will continue to routinely publish data about EEA doctors practising in the UK to provide up-to-date information and assurance for employers.

2 We must help the UK medical profession to evolve to meet the future needs of patients and healthcare

How we will help

- The GMC has a role to play in supporting doctors to adapt to changes while ensuring patient safety.
- We have been working with the medical colleges and faculties to transform their postgraduate curricula. By 2020 these curricula will include high level learning outcomes with some sharing content.
- We are carrying out similar transformational work at undergraduate level. In 2018 we'll complete this work and roll them out to UK medical schools so they can begin to adapt their study programmes for students.
- The potentially growing role of other healthcare workers in areas traditionally reserved for doctors, such as increased roles for nurses or the increasing number of medical associate professions (MAPS), will necessitate co-ordination and the sharing of expertise between regulators.

- We have responded to the UK government's consultation on MAPs advising there is a strong logic that one regulator, the GMC, should be responsible for both doctors and MAPs. If health services make greater use of these roles in the future, this could help ease the pressure being experienced by doctors.

3 We must reduce the pressure and burden on doctors wherever possible

- In December 2017 we announced that all doctors will receive a fee reduction of £35. From April 2018 we will introduce a substantial fixed-term discount for UK doctors during their first six years on the register, saving them over £1,000.
- In March 2018 we will publish updated guidance for doctors on collecting supporting information for their appraisal and revalidation.
- From April 2018 we will reduce our registration fees for all doctors and introduce a substantial fixed term discount for doctors in their early years of practice.
- We will continue to find ways to streamline our fitness to practise investigations, lessening their impact on doctors and complainants where we can.

4 We must improve the culture of the workplace, making employment and training more supportive and flexible

How we will help

- We will continue to use our national training surveys to monitor the impact of service pressures, taking action in partnership with others to tackle education concerns affecting the quality of training and the wellbeing of doctors.
- We will continue to encourage doctors training in England to report concerns about their education, through the new exception reporting system managed locally by the new guardians of safe working hours. We will support similar reporting initiatives in the other three countries of the UK, such as the scheme introduced in Scotland to monitor the working hours of doctors in training.
- In spring 2018 we will publish further qualitative research to help us and others understand how doctors proceed through training and why it's becoming more common for them to take breaks.
- We will start work on this in January 2018 to tackle the impact that working in medicine has on doctors' mental health and wellbeing, bringing together experts from around the UK to advise us where we can best focus our efforts to help the wider profession.
- Our new outcomes for graduates, will include a requirement for medical schools to ensure students can incorporate self-care into their personal and professional lives.

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

In this chapter we look at trends in, and the make-up of, the 236,732 doctors in the UK with a licence to practise, looking at age, gender, place of primary medical qualification and ethnicity. We look at patterns within specialties and changes to the workforce.

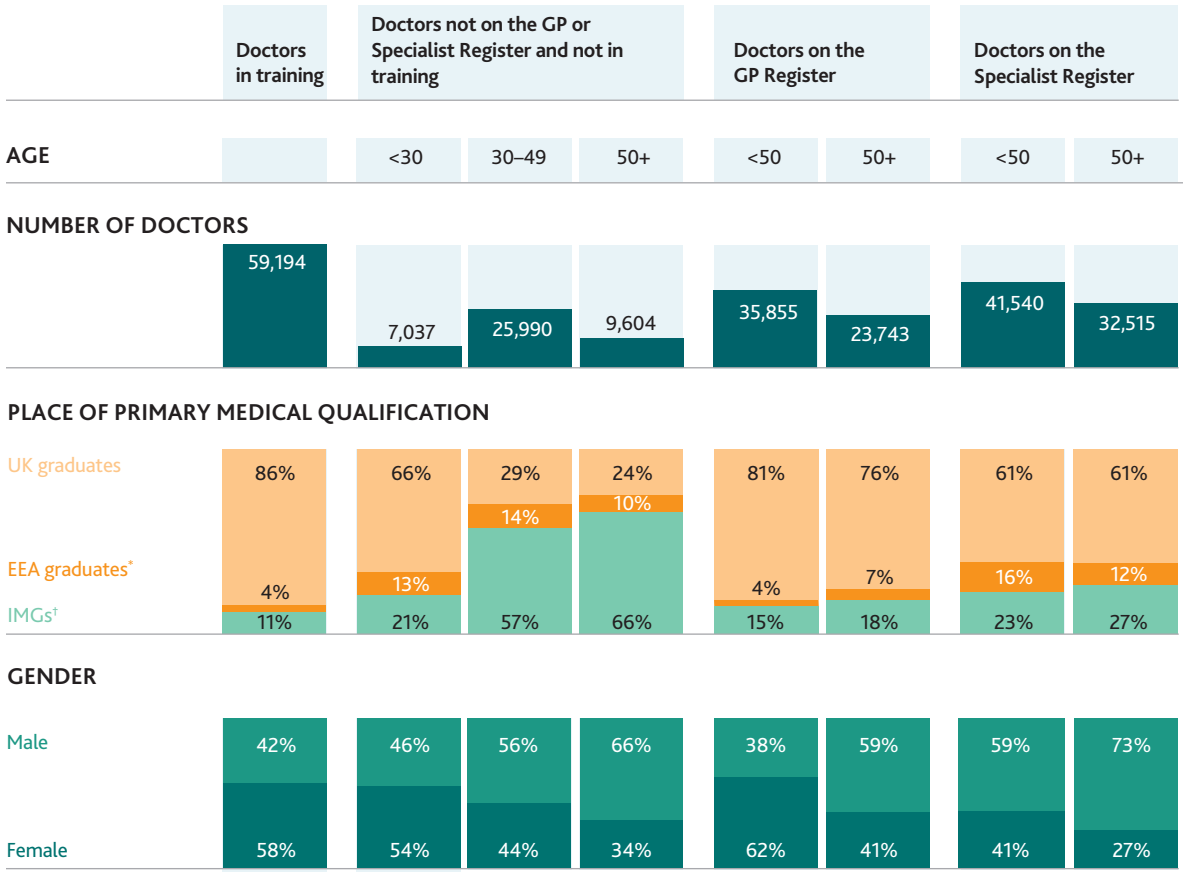
The short-term impact of introducing revalidation on the number of licensed doctors is now diminishing

The introduction of revalidation was expected to lead to a significant number of doctors deciding that they did not need to take up or renew their licence. This happened, with the number of doctors relinquishing their licence each year almost doubling from 7,637 in 2012 to 14,542 in 2015. This effect ran its course by 2016 when the numbers relinquishing their licence began to fall back.

Increase in licensed doctors

During 2017, with the impact of revalidation diminished, the number of licensed doctors has increased after remaining steady for some

Figure 1: Demographic characteristics of licensed doctors on the register in 2017



time. The number of doctors taking up a licence to practise each year has been quite constant between 2012 and 2017: 13,002 took up a licence to practise in 2012, and 13,136 in 2017.

This means that since 2012 total numbers are now up by 2%. However, this rise does not match UK population growth, which has increased by 4%.

Drop in European and international graduates

The policy emphasis on filling shortages of doctors has increased recently – particularly in relation to GPs and some specialties, including emergency medicine, psychiatry, paediatrics and others – through increasing the numbers from overseas. However, between 2012 and 2017, there has been a 37% drop among licensed doctors from Oceania, which includes Australia and New Zealand, a 24% cut in doctors from Northern America and a 20% reduction in doctors from Northwestern Europe.

Concerns around GP shortages

The number of licensed GPs has grown by 3% since 2012, in line with UK population growth, but high vacancies suggest the need is greater than this due to such factors as the ageing population.

Overall growth in specialisms, but some are declining

The overall number of licensed specialists has increased three times faster than GPs – 9% since 2012 with the largest increase being for emergency medicine (25%) but emergency departments remain under pressure.

The 1% fall in the number of licensed psychiatrists between 2016 and 2017 is one reason for increasing concern at shortages in this specialty.

In the ten largest specialties, all bar anaesthetics have increased their reliance on non-UK qualified doctors.

Continued increase in the number of female licensed doctors

Female doctors are inching closer to parity with male doctors, making up 47% of all licensed doctors in 2017.

A rapid growth in the number of younger female doctors has led to an over-representation of female doctors aged under 30 years. This is now returning towards gender parity. In 2017 there were 2% fewer female doctors under 30 years old than in 2012 and 16% more male doctors under 30 years old.

Our data on 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 the specialties where doctors were training and trends in part-time working in training posts.

Data in this section relate to medical students from 2012 to 2016 and doctors in training from 2012 to 2017.

Reduction in students but future plans to increase places

There were 39,185 medical students at UK universities in 2016 compared with 41,422 in 2012, a drop of 5.4%. There are now plans in place to increase medical school places in England from September 2018.

The UK is continuing to attract European and international medical students

The proportion of medical students coming from the UK, Europe and overseas in 2016 is broadly similar to the proportion in 2012, though the proportion of students with non-UK nationalities has increased slightly.

Different ethnic make-up of graduate entry students

8% of those who entered medical school in 2016 had already completed a degree in another subject. Almost three quarters of these graduate entry students identified as white compared with 58% on standard entry programmes.

There is a higher proportion of international students in graduate entry programmes compared with school leaver programmes (16.6% versus 11.7%).

Increase in UK graduate doctors in training

In 2017 there are 60,810 doctors in training, an overall increase of 1.7% since 2012, which does not match the UK population growth of 3.7%.

The number of UK graduates in training, however, has increased by 11.3% since 2012, while the number of international medical graduates has decreased by 39.6%.

More accurate recording of ethnicity and disability data

The GMC has changed the way it records data on ethnicity of doctors in training, enabling more sources of information to be used. This has reduced by a quarter the number of times ethnicity is not recorded. Almost a third of UK graduate doctors in training identify as black, or minority ethnic (BME).

The number of doctors in training with a declared disability has increased to 1.9% in 2017 from 0.6% in 2012. This increase could be partly down to the fact that doctors now have more opportunities to provide this information.

Psychiatry reducing its reliance on overseas graduates

Psychiatry has the highest proportion of doctors in training who graduated overseas, but its reliance on them is reducing, dropping from 48% in 2012 to 31% in 2017.

A third of doctors training to be surgeons are female

Female doctors continue to make up most doctors in training in 2017, at 58%. Almost a third of doctors training to be surgeons are female, which is up from a quarter in 2012, but it remains the specialty with the lowest proportion of female doctors. They make up just 12% of licensed surgeons.

Complaints about doctors (Chapter 3)

This chapter sets out the number of complaints received by the GMC in 2016 and how these complaints have been resolved at the initial and investigation stages of the fitness to practise process. It also examines trends from 2011 to 2016 and changes in the source of these complaints.

Most complaints come from the public

The public accounted for nearly 70% of complaints made in 2016. The rise in complaints from 2011 to 2013 and the subsequent fall largely reflected a surge in complaints from the public that then diminished.

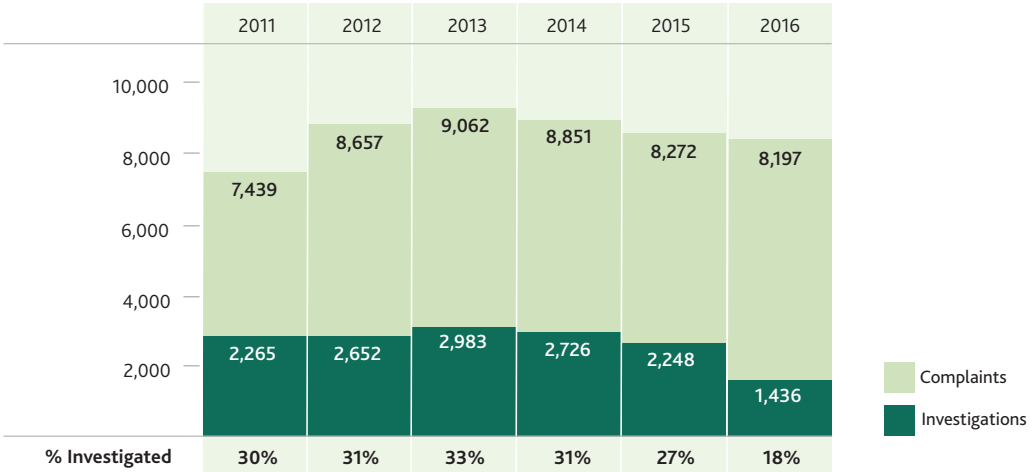
Concerns from employers are continuing to decline

The number of concerns raised with the GMC by doctors' employers has fallen each year since 2012 and particularly sharply in 2016, down by 35% from 2015. This may reflect the impact of responsible officers helping to resolve and prevent more issues locally, supported by the GMC's Employer Liaison Service (ELS).

Impact of provisional enquiries

The provisional enquiries process was introduced after being piloted in 2014. This system has avoided the need for around 700 full investigations, most of which emanated from complaints made by the public.

Figure 2: All complaints and proportion of which were investigated, from 2011 to 2016



Overall, the proportion of complaints investigated dropped from 33% in 2013 to 18% in 2016 (see figure 2, page 29).

Increase in self-referral complaints

The number of complaints through doctor self-referrals increased by 65% from 2011 to 2016. Many of these are over health concerns, criminal investigations or convictions.

Changes to our fitness to practise processes

We have made several changes to our fitness to practise processes in addition to the introduction of provisional investigations. We have introduced other services such as the Doctor Liaison Service, the Patient Liaison Service and the Doctor Support Service.

We may be seeing the impact of these in the trends reported, but further extensive evaluation would be necessary to be definitive about the impact of each.

Increase in proportion of investigations ending in suspension or erasure

In 2016, 2,014 investigations were concluded, of which 7% resulted in conditions or undertakings (147) and 9% resulted in suspension or erasure (176).

Groups of doctors with higher rates of complaints and investigations (Chapter 4)

In this chapter we examine the relative prevalence of a doctor being complained about, having a complaint investigated, and receiving a sanction or a warning for the five-year period from 2012 to 2016. We also consider variations in rates by register type, source of complaint, age, gender and allegation type.

Fewer than one in 100 doctors received a sanction or a warning

In the five-year period from 2012 to 2016, about one in ten doctors were complained about. The vast majority – more than 99 out of every 100 – did not receive a sanction or a warning.

Even in groups with a higher rate of receiving a sanction or a warning a great majority do not receive sanctions or warnings

Even in groups with a higher rate of receiving a sanction or a warning from the GMC, the great majority do not receive sanctions or warnings. Therefore even in groups of doctors with double the likelihood of others, only a very small minority are subject to sanctions or warnings.

Different sources of complaints are associated with different allegation types

The public tend to complain about professional performance and clinical competence while more than half of the allegations made by the police or by doctor self-referrals relate to probity or criminality.

Health allegations are most often raised by employers or by doctor self-referrals. These allegations are most likely to lead to a sanction or a warning.

Rate of complaint, investigations, and sanctions or warnings for different groups of doctors

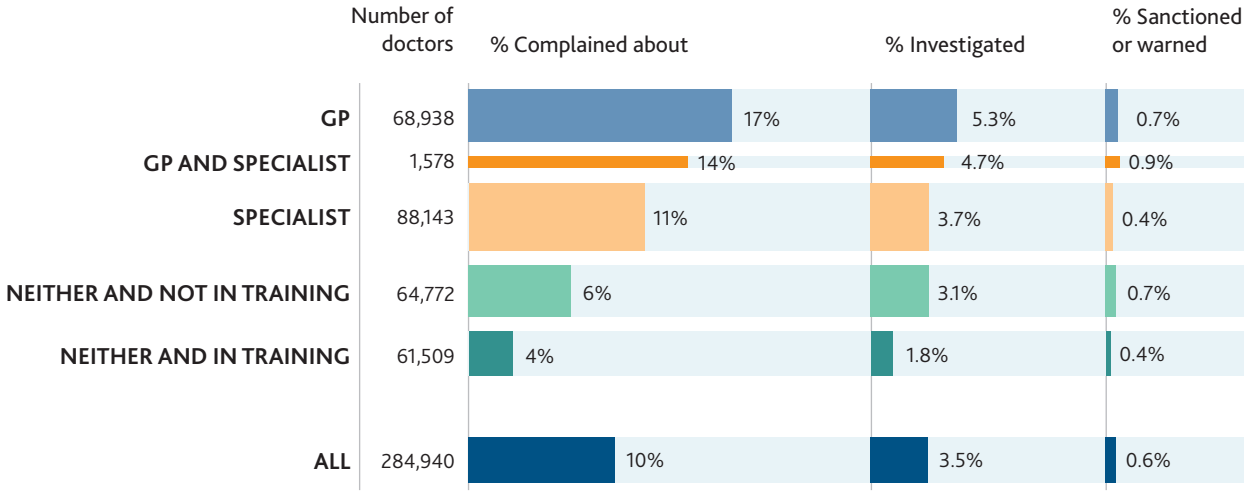
Specialists in occupational medicine and psychiatry had the highest rate of being complained about.

Amongst the four largest specialty groups, a lower percentage of UK graduates and female doctors received a sanction or a warning between 2012 and 2016 compared with doctors who graduated outside the UK or male doctors.

Despite a lower proportion being complained about, doctors on neither the Specialist or the GP Register who are not in training had the highest rate of investigations leading to a sanction or a warning (see figure 3, page 32 and figure 39, page 96).

Male GPs had the highest rate of being complained about compared with female GPs and other register types. GPs who graduated outside the UK were at an increased prevalence of receiving a sanction or a warning compared with those who graduated in the UK.

Figure 3: The proportion of doctors complained about, investigated, and sanctioned or warned, by register, from 2012 to 2016



Regional and country differences in our data about doctors (Chapter 5)

In this chapter we look at variations in how the medical workforce is deployed and distributed across the countries of the UK and regions of England (see figure 4). For the first time, in this year's report, we can present country and regional data showing changes from 2012–2017.

Fewer younger doctors and GPs in Wales

In the overview we discuss the importance of being able to attract doctors to rural areas, and shortages of doctors. Our data show trends in Wales that bear this out. There has been almost no increase in doctors aged under 50 years in Wales from 2012 to 2017, which suggests a difficulty attracting younger medical professionals.

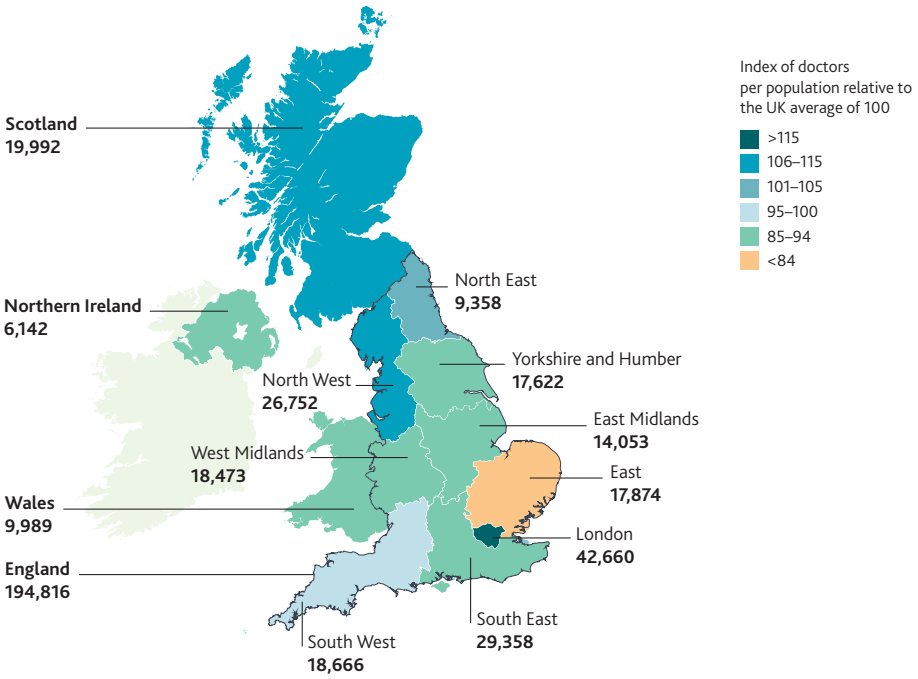
Also, there are fewer GPs per head of population in Wales (0.83 per 1,000 people), compared with Scotland (1.11), England (0.90) and Northern Ireland (0.93).

Regional and national differences

Scotland has slightly more licensed doctors overall per head of population than the UK average, and the East region of England has the fewest (see figure 4.)

London has the highest density of specialists, with 1.63 per 1,000 population, far more than the second densest region, the North East of England, which has 1.21.

Figure 4: Number of licensed doctors relative to the population* in 2017



* Excludes 2% of licensed doctors with unknown location

The English workforce has become more female than others

Wales and the English Midlands are the furthest from female-male parity. In Wales, 45% of doctors are female, compared with a UK average of 47%. However, from 2012 to 2017 the proportion of female doctors in Wales increased from 41% of licensed doctors to 45%.

The medical workforce in England has become more female than other countries with a 16.5% increase over the six-year period, from 2012 to 2017, compared with Wales, where there was a 10% increase.

Northern Ireland less dependent on non-UK graduates

Northern Ireland is less dependent on non-UK graduates than other countries and regions, with only 14% of licensed doctors having gained their primary medical qualification outside the UK. This is consistent with Northern Ireland training and retaining a greater proportion of its medical workforce, potentially due to its geographic separation from mainland UK and other factors.

Complaints that lead to an investigation were higher in Wales

Just over two fifths of complaints (41%) in Wales led to a doctor being investigated. In England 37% of complaints resulted in an investigation. This was slightly higher than the overall UK figure of 36%. Fewer complaints led to a doctor being investigated in Northern Ireland and Scotland (33% and 32% respectively).

The rate of investigations resulting in a sanction or a warning was broadly similar between UK countries

The proportion of investigations that lead to a sanction or a warning was close between the countries. Scotland and Wales, at 17%, were only slightly higher than England (16%) and Northern Ireland (15%).

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