

General
Medical
Council

The state of medical education and practice in the UK

2017

Working with doctors Working for patients

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and practice in the UK

2017

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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 prescriptive² 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 consultation³ 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 report³² 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 training³⁸ 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 graduates³⁹ – 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 consultation³ 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 system⁴³ 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

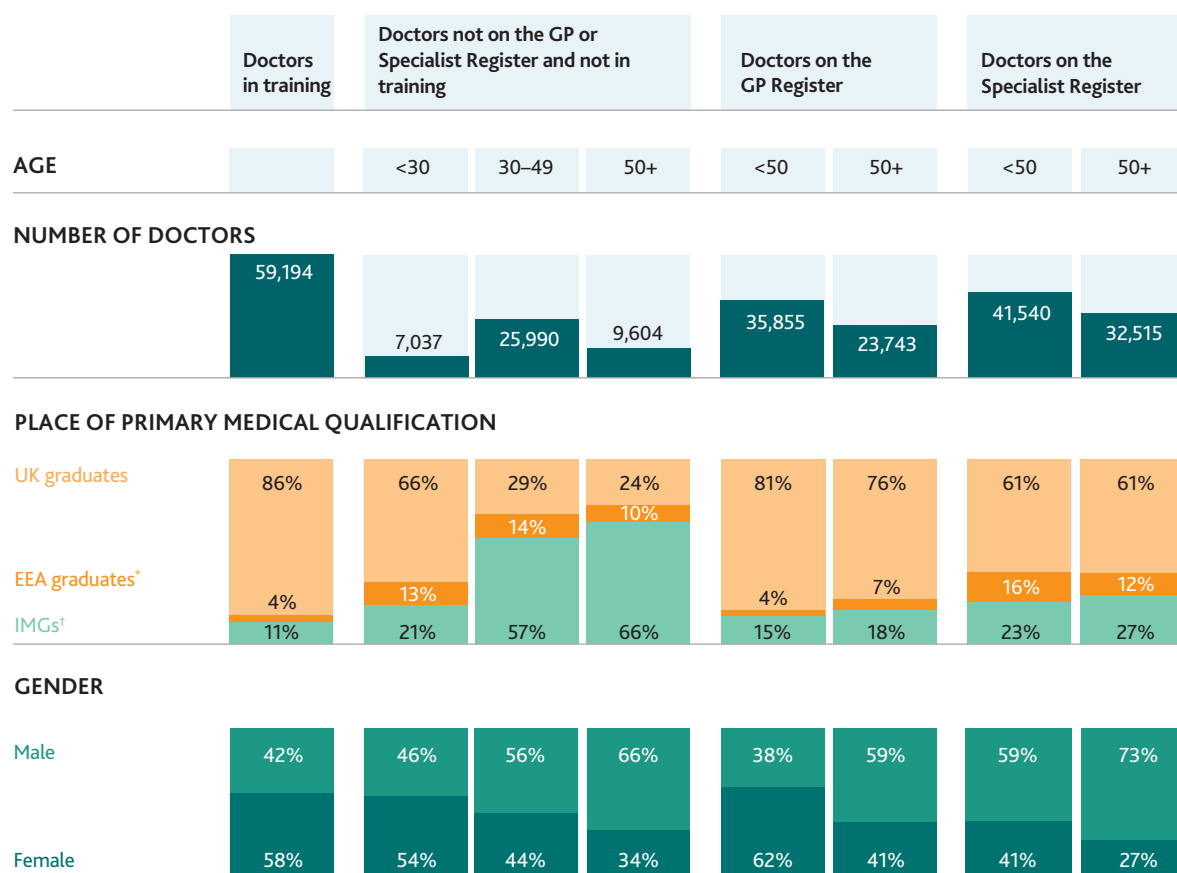
The introduction of revalidation was expected to lead to a significant number of doctors

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.

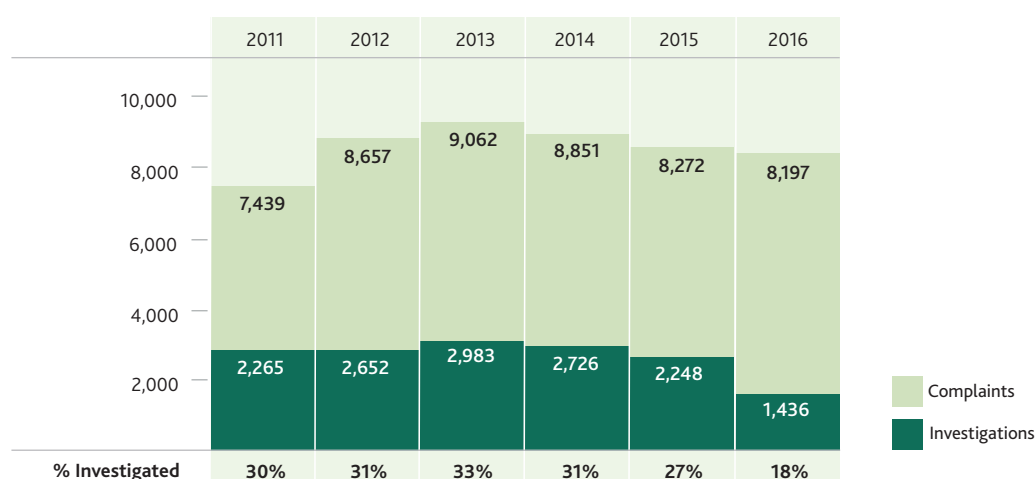
Concerns from employers are continuing to decline

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

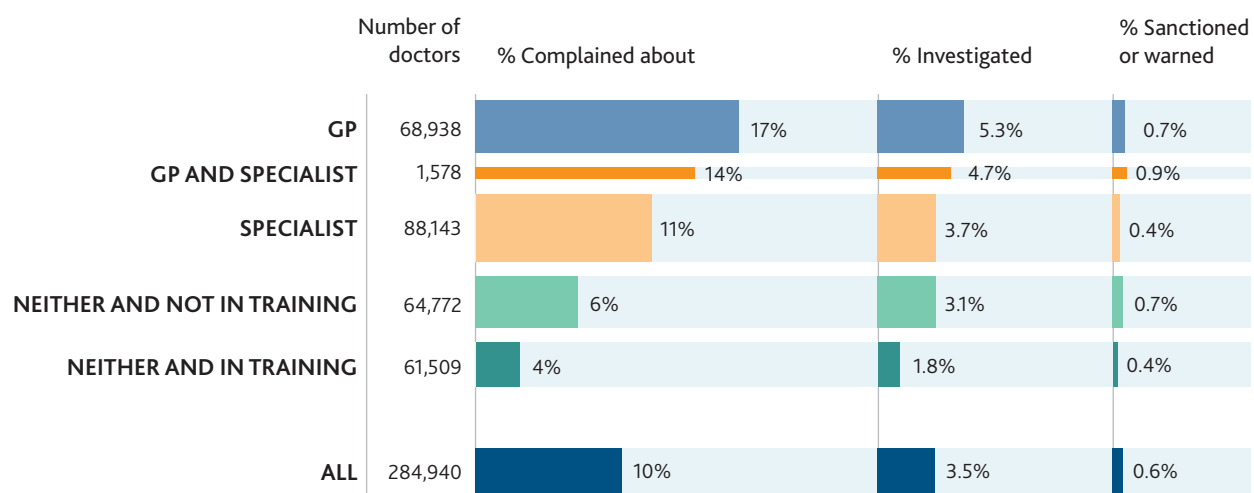
Specialists in occupational medicine and psychiatry had the highest rate of being complained about.

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.

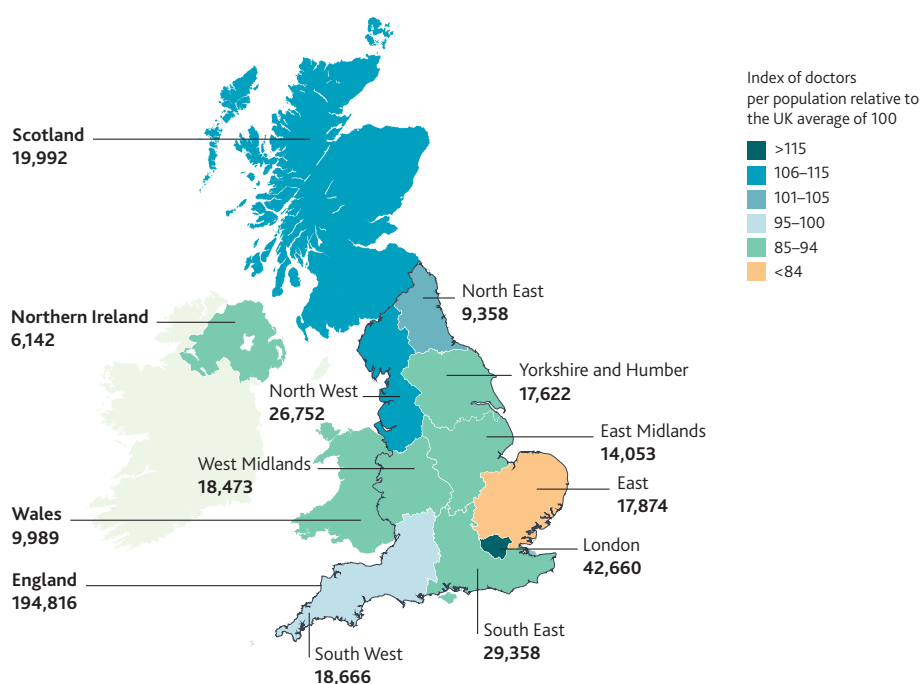
Also, there are fewer GPs per head of population in Wales (0.83 per 1,000 people), compared with Scotland (1.11), England (0.90) and Northern Ireland (0.93).

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%).



1 Our data on doctors working in the UK

Summary

This chapter looks at trends in, and the make-up of, the 236,732 doctors in the UK with a licence to practise. This is the pool of doctors available to the workforce – and we use ‘workforce’ in this sense rather than to describe the numbers actually working. We have highlighted in the overview chapter the pressures being felt in the health system and some of the data here may be of particular interest to workforce planners – as well as the data we present in chapter 5, which looks at differences across the countries and regions of the UK.

- The number of licensed doctors has increased by 2% in 2017 after remaining steady for some time. Two trends have effected the overall number of licensed doctors. First, there has been a steady flow of between 12,000 and 13,000 doctors a year taking up a licence. Second, between 2013 and 2016 there was an increase in doctors relinquishing their licences but remaining on the register following the introduction of revalidation. In 2017 there has been a reduction in the number of doctors relinquishing their licences and although it is not clear to what extent revalidation directly influenced the number of doctors giving up their licenses it is believed to have played a part.
- The growth in 2017 may continue as the numbers of doctors relinquishing their licence has fallen back now that the one-off impact of introducing revalidation has worked through. One net effect of revalidation was to increase the number of doctors on the register with no licence to practise.

There is an increasing policy emphasis on filling shortages of doctors – particularly general practitioners (GPs) and some specialties, including emergency medicine, psychiatry, paediatrics and others – through increasing the numbers from abroad. However:

- between 2012 and 2017, there has been a 37% drop among licensed doctors from Oceania, which includes Australia and New Zealand, a 24% drop in doctors from North America and a 20% drop in doctors from Northwestern Europe
- our largest traditional supply of international doctors, from South Asia, has fallen by 2,509 in absolute terms, a 7% fall
- within Europe, Southern Europe has increased slightly compared with 2012 but has been declining since 2015.

There are particular concerns currently around GP shortages:

- The number of licensed GPs has grown by 3% since 2012, broadly in line with UK population growth, but high vacancies

suggest the need is greater than this due to such factors as the ageing population.

- Almost 54% of GPs are female and the GP workforce is getting younger – in general this is positive but in some places there are concerns about the numbers approaching retirement.

The specialist workforce is growing faster than the GP one but some individual specialists are growing very fast and some are declining.

- The overall number of licensed specialists has increased 9% since 2012.
- The largest increase has been for emergency medicine (25%) but emergency departments remain under pressure.
- A 1% fall in psychiatrists between 2016 and 2017 is one reason for increasing concern at shortages in this specialty.
- In the ten biggest specialties, all bar anaesthetics have increased their reliance on non-UK-qualified doctors.

There has been a decline of 8% in the number of licensed doctors who are neither GPs nor specialists and who are not in training, in contrast to the growth elsewhere. These doctors cover a wide range of different roles and it is not clear if this is a cause for concern.

In terms of broad demographic change a key trend has been the continuing increase in the

number of female licensed doctors and the increasing ethnic diversity of doctors with a UK primary medical qualification.

- Female doctors are inching closer to parity with male doctors, making up 47% of all licensed doctors in 2017. But the number of male younger doctors is gradually catching up - there has been a 16% increase between 2012 and 2017 in male doctors who are under 30 years old.
- A rapid growth in the number of younger female doctors has led to an over-representation of female doctors under 30 years old. 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.
- More than a third (35%) of specialists are female. In public health, as with paediatrics and obstetrics and gynaecology, over 50% of doctors are now female. Surgery remains 88% male despite a nearly 50% increase in the number of female surgeons in the years 2012 to 2017.
- The ratio of licensed UK graduates identifying as white compared with black and minority ethnic (BME) has declined from 4:1 to a little more than 3:1 since 2012.

The 2017 register

In 2017*, there were 281,323 doctors on the UK medical register. Of these, the clear majority, 236,732, were licensed to practise and therefore able to treat patients. The remainder were non-licensed, unable to practise as a doctor in the UK.

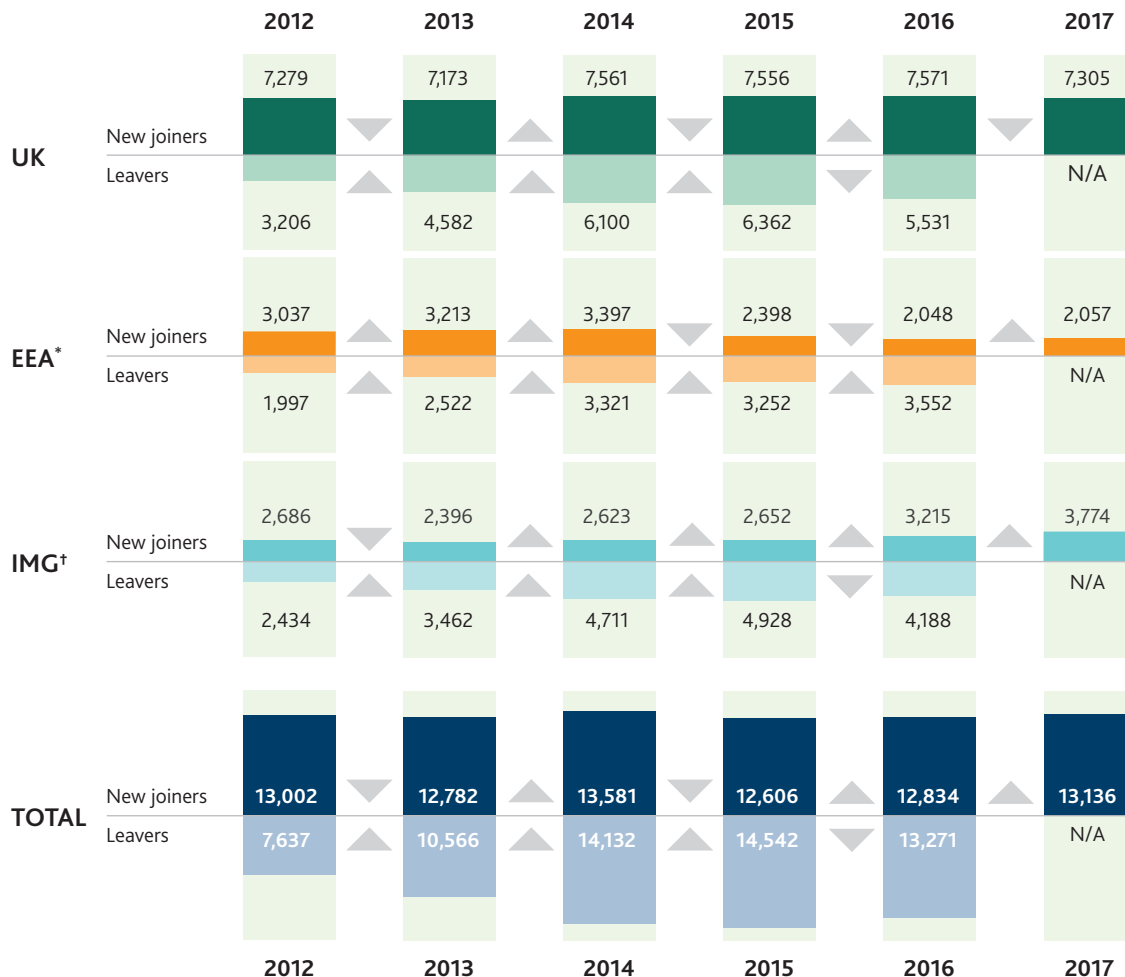
The short-term impact of introducing revalidation on the number of licensed doctors is now diminishing

Over the period between 2012 and 2017 two trends have affected the overall number of licensed doctors. First, a steady flow of between 12,000 and 13,000 doctors a year taking up a new licence to practise (see figure 5, page 39). Second, since the start of 2013 there has been an increase in doctors relinquishing their licence: this is now diminishing. This surge coincided with the introduction of revalidation in December 2012. It is not clear to what extent this directly influenced the number of doctors giving up their licences though it is believed to have played a part. We believe that most of these licensed doctors were working overseas or no longer in practice which is why they relinquished their licences.

Revalidation requires doctors to be revalidated as fit to practise every five years. 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 indeed 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. Although we do not have figures for 2017 the indication is that this has continued to fall back towards the long-term trend before revalidation was introduced. There remain a number of other reasons why a doctor might relinquish their licence to practise, such as taking a career break, moving into research rather than direct practice, or a period of ill health.

* Our data for 2017 are based on the register at 30 June, 2017

Figure 5: Number of doctors relinquishing or gaining a licence to practise, from 2012 to 2017



Box 1: Joiners and leavers

Joiners are those doctors who became licensed for the first time to practise in the UK or become licensed after a period of being unlicensed for at least two years. Leavers are those who gave up their licence and stopped practising in the UK.

For example, if a doctor gains a licence in 2010, practises until 2012, relinquishes the licence to go abroad and returns to the UK in 2016 and takes up a licence again, he or she would be considered a 'joiner' for a second time.

We do not have the leaver figures for 2017 in Figure 5 as these doctors need to have left for a full year to be counted.

* 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.

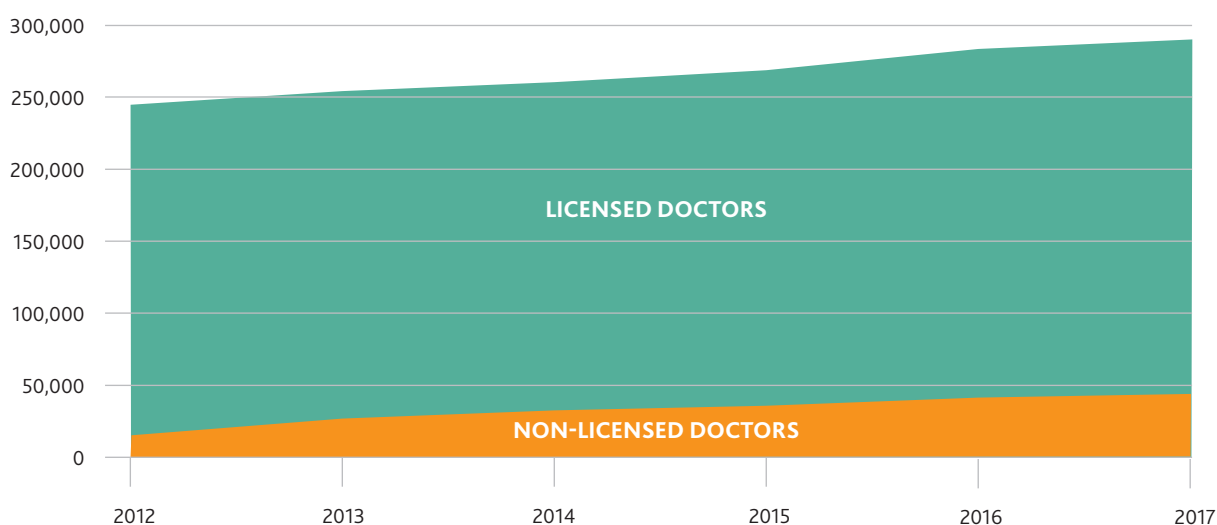
† International medical graduates (IMGs) are doctors who gained their primary medical qualification outside the UK, EEA and Switzerland, and who do not have European Community rights to work in the UK.

The number of licensed doctors has increased after a period of remaining steady

The net effect of the introduction of revalidation, the steady flow of doctors onto the register and other factors has been that between 2012 and 2016 the overall number of licensed doctors remained broadly constant. But in 2017 the number of licensed doctors has risen once more (by 4,482 or 2%) as the flow of doctors taking up a licence has continued at previous levels while the impact of the introduction of revalidation on those relinquishing their licence has reduced.

Many of the doctors relinquishing their licence after the introduction of revalidation have chosen to stay on the medical register without a licence to practise. As a result the total number of doctors registered has continued to rise between 2012 and 2017, even during the period when the number of licensed doctors remained steady. In 2017 there were 35,000 more registered doctors than in 2012 (see figure 6).

Figure 6: Number of licensed and non-licensed doctors on the medical register, from 2012 to 2017, as of 30 June, 2017



The number of licensed doctors per head has declined

The overall rise in the number of licensed doctors in the UK between 2012 and 2017 of 1.9% is slower than the population growth of 3.7% in the same period.⁴⁴

New models of care or new use of technology and innovation may mean fewer doctors are required per head of population, but this is concerning in the context of capacity and workload concerns raised in our Overview.

Box 2: Doctors without a licence to practise

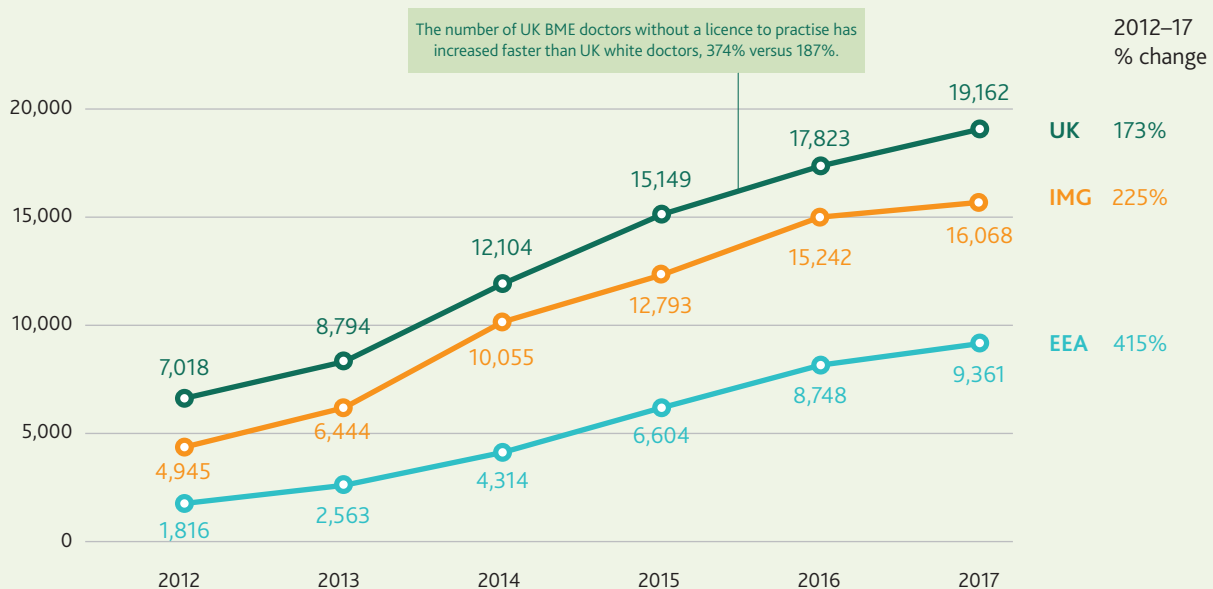
The number of non-licensed doctors increased substantially, peaking with a 49% increase in 2014, which has now slowed to 7% in 2017 as the impact of revalidation's introduction has worked through.

Until June 2014, EEA graduates who joined the medical register were automatically licenced. But since June 2014, EEA graduates must now show proof of their English language capability before they gain a licence to practise. This may help to explain why the number of registered EEA graduates has increased over time, yet the number of licensed doctors has decreased.

Very high relative growth in number of EEA graduates without a licence to practise

Between 2012 and 2017 following the introduction of revalidation, the number of doctors on the register who do not have a licence to practise has grown particularly sharply in the case of EEA graduates (see figure 7).

Figure 7: Number of non-licensed doctors by primary medical qualification (PMQ) region, from 2012 to 2017



The number of EEA graduates without a licence has increased by 415% compared with an increase of 225% for IMGs and 173% for UK graduates.

Doctors on the register but not licensed may be continuing to practise overseas but if they are not actively working in the UK they would not need to be licensed. It is not fully clear why EEA graduates in this situation are more likely to

wish to remain on the register compared with other non-UK graduate doctors, although the EEA graduate population is known to be highly mobile and spends a shorter than average time with a UK licence to practise compared with other types of doctors. Evidence also suggests that medical professionals from the EEA often use the UK as a 'stepping stone' to further mobility.⁴⁵

The changing make-up of the UK medical workforce

In the remainder of this chapter, the figures are for licensed doctors only – those who are most likely to be active in the workforce as medical professionals in the UK. In this section we look at the data for the whole profession. We then consider separately some specific points in relation to GPs, specialists and those who are on neither of these registers and not in training. Chapter 2 considers medical students and doctors in training in more detail.

The growth in new female doctors shows signs of slowing

Female doctors are an increasing proportion of the workforce (up from 43% in 2012 to 47% in 2017) as older, predominantly male, doctors retire and new, predominantly female, doctors join the profession (see figure 8, page 43).

This trend is set to continue: in the under 30 age group, one third more doctors are female than male – 17,466 compared with 12,977.

However, there are signs that the younger part of the workforce is moving more towards a gender balance, and that the period of rapid growth in the number of female doctors, which has led to an over-representation of female doctors among younger doctors, is coming to an end. In 2017 there were 2% fewer female doctors under 30 years old than in 2012, while there has been a 16% increase in male doctors for this age group.

Figure 8: Changes in the gender and age of licensed doctors on the medical register, from 2012 to 2017

		2012		% change	2017	
		% total	Number of doctors		% total	Number of doctors
TOTAL		100%	232,250	2%	100%	236,732
Gender						
All doctors	Male	57%	132,553	-5%	53%	125,748
	Female	43%	99,697	11%	47%	110,984
Age (years) and gender						
Under 30 years	All	12%	29,005	5%	13%	30,443
	Male	5%	11,149	16%	5%	12,977
	Female	8%	17,856	-2%	7%	17,466
30–49 years	All	58%	135,498	3%	59%	139,308
	Male	31%	73,034	-7%	29%	68,202
	Female	27%	62,464	14%	30%	71,106
50 years and over	All	29%	67,747	-1%	28%	66,981
	Male	21%	48,370	-8%	19%	44,569
	Female	8%	19,377	16%	9%	22,412

Where our doctors come from

Figure 9: Source of licensed doctors on the register, from 2012 to 2017

	2012			2017	
	% total	Number of doctors	% change	% total	Number of doctors
GRADUATES					
ALL	100%	232,250	1.9%	100%	236,732
UK	63%	147,354	7.3%	67%	158,121
EEA	10%	22,967	-5.9%	9%	21,609
IMGs	27%	61,929	-8.0%	24%	57,002

The number of licensed doctors who were UK graduates increased by 7% between 2012 and 2017, whilst the number who were EEA graduates and international graduates fell 6% and 8% respectively. The share of UK graduates thus rose from 63% to 67% (see figure 9).

When looking at regions and countries within these large groups a change in the flow of doctors is evident (see figure 10, page 45). Between 2012 and 2017 a 7% increase in UK graduates has been partially offset by a fall in the numbers from all other parts of the world, except Southern Europe and two regions that provide a relatively small proportion of licensed doctors to the UK: Southern America and the Caribbean, and non-EEA Europe. The ambition to increase the supply of GPs with European and international graduates will therefore require a reversal of recent trends.

Fewer doctors from South Asia, Australia, Northern America and Africa

South Asia has been the largest source of international doctors historically and accounts for the largest part of the fall in the number of international doctors, though the change (a 7% reduction) is less than for some areas, notably doctors from Australia, New Zealand and the rest of Oceania (down 37%), from Northern America (down 24%) and from Africa (down 14%). It might be the case that economic conditions in some of these countries (such as the recent growth of the Indian economy and gradual end of the global economic slowdown) have made emigration to the UK less attractive than previously. It is not possible to say for sure what is causing this effect across such a diverse range of countries.

The source of European doctors is changing

There has been a 20% reduction in doctors from Northwestern Europe and a 7% increase from Southern Europe between 2012 and 2017, though since 2015 the numbers from Southern Europe have also been declining. This could be due to

the previously poor economic situations in Spain, Italy, Greece and Portugal improving in the past couple of years.^{46, 47, 48, 49}

The impact of the vote to leave the European Union on the number of EEA graduates working remains unclear.

Figure 10: Licensed doctors by region of the world where doctors gained their primary medical qualification, from 2012 to 2017

United Kingdom (UK)	2012	2013	2014	2015	2016	2017	2012–17 % change
	147,354	150,047	151,507	153,005	155,032	158,121	7%
EEA							
Northwestern Europe	9,011	8,681	8,153	7,625	7,227	7,205	-20%
Central Europe, Eastern Europe, Baltic countries	6,926	7,062	7,095	6,903	6,724	6,874	-1%
Southern Europe	7,030	7,974	8,544	8,345	7,588	7,530	7%
IMG							
Non-EEA Europe	1,560	1,617	1,645	1,645	1,631	1,678	8%
Northern America	303	300	268	239	218	230	-24%
South, Central and Latin America, & the Caribbean	1,533	1,565	1,596	1,559	1,539	1,594	4%
Africa	11,485	11,032	10,066	9,612	9,463	9,862	-14%
Middle East	7,152	7,169	6,918	6,785	6,674	6,980	-2%
South Asia	36,191	35,737	34,595	33,662	33,243	33,682	-7%
Rest of Asia	1,725	1,709	1,610	1,600	1,637	1,724	0%
Oceania	1,980	1,782	1,501	1,350	1,216	1,252	-37%

Broad areas of practice

In addition to being on the medical register, doctors who have gained their Certificate of Completion of Training (CCT) as a GP or a specialist can apply to join the GP Register or the Specialist Register. Doctors who qualified in other countries can also join the GP or Specialist Register by providing the GMC with proof of their equivalent qualifications and competence.⁵⁰ 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 considered separately in chapter 2.

In 2017, out of every dozen licensed doctors, four were specialists, three were GPs, three were in training and two were none of these (see figure 11).

Figure 11: The change in the number of licensed doctors by register type, from 2012 to 2017

	2012		% change	2017	
	% total	Number of doctors		% total	Number of doctors
TOTAL	100%	232,250	2%	100%	235,478
GP	25%	57,736	3%	25%	59,598
Specialists	29%	68,019	9%	31%	74,055
Neither register and not in training	20%	46,367	-8%	18%	42,631
Neither register and in training	25%	58,835	1%	25%	59,194

The GP workforce

We consider in this section the GP workforce, with the changes in its numbers and make-up presented in the context of the other areas of practice to give perspective.

Slow growth in the number of licensed GPs compared with specialists

The number of licensed GPs has grown at only a third of the rate of specialists between 2012 and 2017. This is at about the same rate as the population growth in the UK, but demand for GP services is outstripping this due to factors such as the ageing population. An increasing proportion of GPs are also working as locums.⁵¹

The GP Register is getting younger and more female

The proportion of GPs who are aged 50 years and over has reduced slightly (by 3%) and the overall increase in the number of GPs is being driven by an increase in the number of younger GPs. This is good news overall, although in some areas of the country there are concerns at the numbers of older GPs reaching retirement, especially in rural areas (see figure 12).^{52, 53}

The GP workforce is considerably more female than any other part of the profession with the exception of paediatrics, obstetrics and gynaecology, and public health (see figure 15, page 50). It continues to become more so, though the proportion who are female is rising more slowly than is the case for specialists.

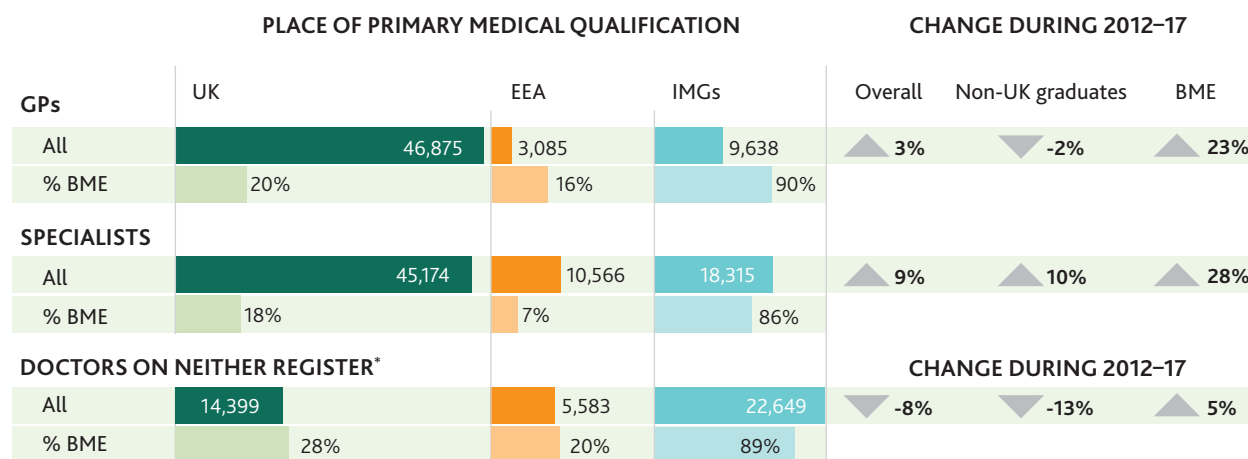
Figure 12: Age and gender of the workforce and change, from 2012 to 2017

	AGE (YEARS)				CHANGE DURING 2012–17		
	Under 40	40–49	50 and over	TOTAL	Overall	50 and over	Female doctors
GPs							
All	17,340	18,515	23,743	59,598	▲ 3%	▼ -3%	▲ 16%
% female	66%	58%	41%	54%			
SPECIALISTS							
All	10,968	30,572	32,515	74,055	▲ 9%	▲ 12%	▲ 25%
% female	47%	39%	27%	35%			
ON NEITHER REGISTER AND NOT IN TRAINING							
All	22,394	10,633	9,604	42,631	▼ -8%	▼ -26%	▲ 1%
% female	50%	39%	34%	44%			

The GP workforce is increasingly reliant on UK graduates, but is ever more ethnically diverse

There has been a 23% increase in GPs who describe themselves as BME practising in the UK (see figure 13, page 48). This is primarily

driven by an increase in the ethnic diversity of UK graduates becoming GPs (in contrast to specialties where more of the greater diversity is driven by an increase in non-UK graduates). Overall, 31% of UK-trained GPs describe themselves as BME.

Figure 13: Place of primary medical qualification and ethnicity of licensed doctors, from 2012 to 2017

The specialist workforce

The specialist workforce overall has grown by 9% between 2012 and 2017, nearly five times as fast as the 2% growth in licensed doctors overall.

Growth in emergency medicine, general medicine, and paediatrics specialties

As shown in figure 14, page 49, the fastest growth has been in the number of licensed emergency medicine doctors, partly in response to pressures in emergency departments in recent years.⁵⁴ There has also been significant growth of more than 15% in medicine and paediatrics.

Decline in the number of licensed psychiatrists

There has been great concern at the shortage of psychiatrists and among the larger specialties this is the only one to have shown a decline, albeit a small one of 1%.

* Change during 2012-17. 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 14: The change in the number of licensed doctors on the Specialist Register by specialty group, from 2012 to 2017*

	2012		2017
	Number of doctors	% change	Number of doctors
SPECIALISTS	69,312	9%	75,309
Medicine	16,626	16%	19,367
Surgery	12,479	8%	13,482
Anaesthetics and intensive care medicine	9,408	7%	10,104
Psychiatry	8,137	-1%	8,096
Radiology	5,180	9%	5,661
Paediatrics	4,823	16%	5,599
Obstetrics and gynaecology	3,598	8%	3,869
Pathology	3,113	-5%	2,969
Ophthalmology	2,048	9%	2,230
Emergency medicine	1,676	25%	2,091
Public health	1,331	-19%	1,083
Occupational medicine	708	-16%	594
Other specialty or multiple specialty groups	185	-11%	164

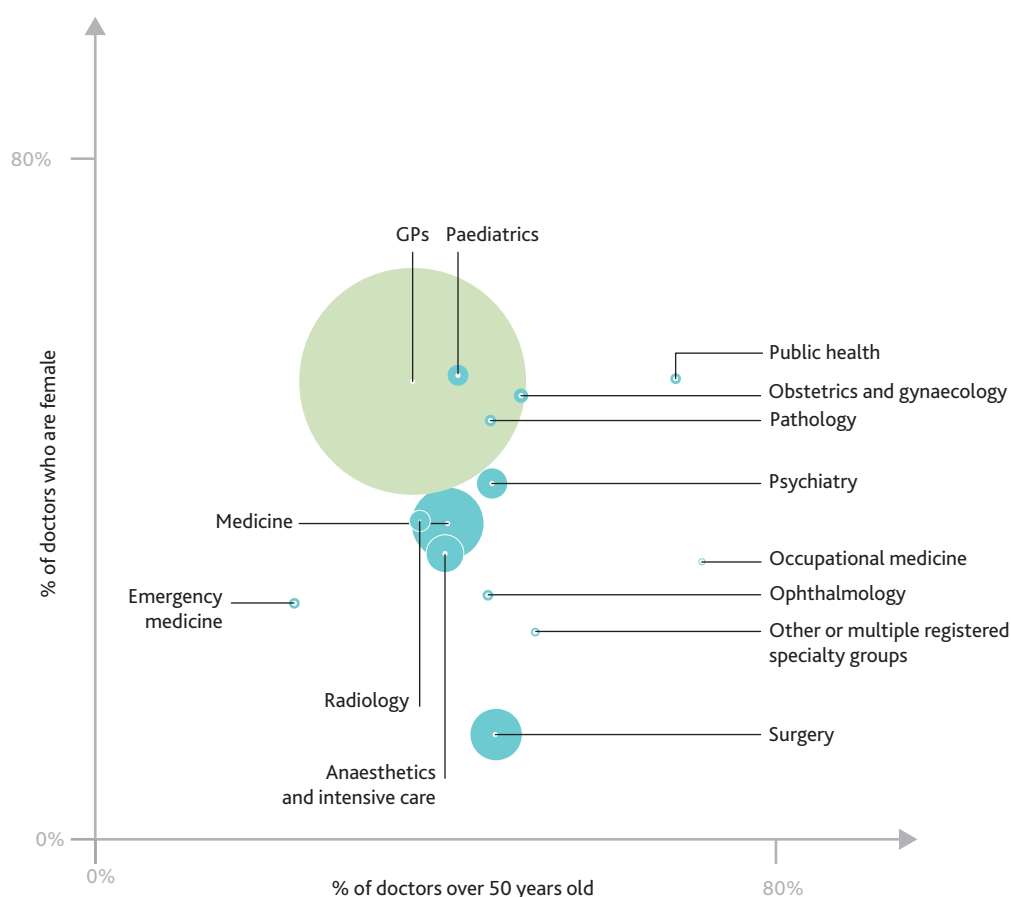
* Figure includes all licensed doctors on neither register, including both those in training and those not in training.

Public health and occupational medicine have a declining number of doctors

Two of the smallest specialties, public health and occupational medicine, have seen relatively sharp declines of 19% and 16% respectively (see figure 14, page 49). They also have the highest

percentage of older doctors – 68% and 72% respectively (see figure 15) and are therefore at risk of having parts of their workforce retire. This may be of concern for workforce planners as a small specialty declining may have a reduced capacity to train new doctors if the specialty needed to increase in size.

Figure 15: Age and gender of licensed doctors by specialty in 2017*



Increase in female specialists will continue

The growth in female doctors has been fastest on the Specialist Register in recent years, with the proportion growing by a quarter between 2012

and 2017. This, however, is from a much lower base than is the case for GPs, and still only 35% are female. The increase is likely to continue as older doctors who are more likely to be male retire. Almost half of specialists aged under 40 years old are female.

* Bubble size denotes number of doctors, ranging in size from 59,598 for GPs to 164 for Other or multiple registered specialty groups.

Three specialties are now made up of more female doctors than male

In 2017, a third specialty, public health, has joined paediatrics and obstetrics and gynaecology in having female doctors make up more than half its members.

Only just over one in ten surgeons is female and the specialty relies on older doctors

Every specialty group has an increasingly female workforce (see figure 16, page 52), including those specialties where at least 50% of their doctors are already female. Certain specialties, though, remain male dominated.

The most male-dominated specialty remains surgery where seven out of eight surgeons are male (88% in 2017). With almost a quarter (24%) of surgeons under 40 years old being female, gender equality in this specialty remains a very long way off. Nevertheless there is progress with a large growth in female doctors in surgery – their numbers increased by 47% from 1,137 to 1,673 between 2012 and 2017.

Surgery also has an increasing reliance on older doctors. Their number increased by 16% while the specialty itself grew by only 8%.

Most specialties are increasingly reliant on non-UK graduates, and are increasingly ethnically diverse

Specialists continue to be reliant on non-UK graduates, with a 10% growth in non-UK graduate doctors working as specialists (see figure 13, page 48). This drives some of the 28% rise in BME specialists as 58% of non-UK graduate specialists are BME compared with only 18% of UK graduate specialists.

Emergency medicine and medicine have seen the greatest relative increase in BME doctors and in non-UK qualified doctors, as growth in these specialties is strongly driven by recruitment overseas. All specialties in the top ten, with the exception of anaesthetics, have increased their reliance on non-UK-qualified doctors. The specialties with the most 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 non-UK graduates.

Overall, obstetrics and gynaecology has the most BME doctors as a proportion and emergency medicine the least. Certain specialties have far higher proportions of UK graduate BME doctors, such as radiology, which is 22% UK graduate BME compared with anaesthetics which is 12%.

Figure 16: Age and gender of the ten largest specialties in 2017 and change, from 2012 to 2017



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

Figure 17: Place of primary medical qualification and ethnicity of licensed doctors in the ten largest specialty groups in 2017 and change, from 2012 to 2017

MEDICINE	PLACE OF PRIMARY MEDICAL QUALIFICATION				Total % BME	CHANGE DURING 2012–17		
	UK	EEA	IMGs	Non-UK graduate		Overall	Non-UK graduates	BME
All	12,762	2,531	4,074	6,605		▲ 16%	▲ 23%	▲ 38%
% BME	20%	7%	88%	57%	33%			
SURGERY								
All	8,092	2,602	2,788	5,390		▲ 8%	▲ 4%	▲ 27%
% BME	20%	6%	86%	48%	31%			
ANAESTHETICS AND INTENSIVE CARE								
All	6,535	1,292	2,277	3,569		▲ 7%	— 0%	▲ 28%
% BME	12%	5%	84%	57%	28%			
PSYCHIATRY								
All	4,452	978	2,666	3,644		▼ -1%	▲ 6%	▲ 21%
% BME	15%	6%	86%	65%	37%			
RADIOLOGY								
All	3,748	782	1,131	1,913		▲ 9%	▲ 8%	▲ 23%
% BME	22%	8%	86%	54%	33%			
PAEDIATRICS								
All	2,999	744	1,856	2,600		▲ 16%	▲ 22%	▲ 35%
% BME	16%	7%	89%	66%	40%			
OBSTETRICS AND GYNAECOLOGY								
All	1,730	545	1,594	2,139		▲ 8%	▲ 12%	▲ 26%
% BME	17%	9%	91%	71%	47%			
PATHOLOGY								
All	1,669	415	885	1,300		▼ -5%	▲ 1%	▲ 11%
% BME	14%	6%	80%	58%	34%			
EMERGENCY MEDICINE								
All	1,561	150	380	530		▲ 25%	▲ 26%	▲ 42%
% BME	13%	7%	88%	65%	27%			
OPHTHALMOLOGY								
All	1,157	547	526	1,073		▲ 9%	▲ 12%	▲ 30%
% BME	31%	5%	86%	45%	37%			
PUBLIC HEALTH								
All	852	78	153	231		▼ -19%	▼ -18%	▼ -2%
% BME	14%	5%	82%	57%	24%			

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

The remainder of the non-training workforce

Nearly one in five doctors are on neither the GP nor Specialist Register and are not in training (though they may be in the future). This part of the workforce covers many roles but data on the individual roles within this group are less good than in relation to other parts of the workforce. The GMC will be doing some further research on these doctors in the coming year. They are an important part of the workforce and understanding more about them is vital – particularly as some of these roles may change as new models of care are developed and there is increased use of newly emerging professions such as physician associates.

Decline in the numbers of doctors who are not GPs, specialists or training

Some broad figures for these doctors were shown in figures 11–13 on pages 46 to 48. The number of licensed doctors who are neither GPs nor specialists and are not in training has declined by 8% between 2012 and 2017 at a time when the number in training has been steady. The number of GPs has risen at roughly the same rate as the population (3%) and the number of specialists by 9%. It is unclear whether this decline is a cause for particular concern as it is unclear if it is concentrated in any of the many roles these doctors have.

About 53% of those on neither the GP nor Specialist Register and not in training are aged under 40 years old. It is possible that some may go into, or back to, training in the future. However, this is based on traditional career routes for doctors. It is also possible that some younger doctors do not wish to pursue these routes.

The number of doctors on neither the GP nor Specialist Register, and not in training, who are over 50 years old has declined sharply by 26% between 2012 and 2017, accounting for a significant part of the overall decline in the number of these doctors.

There has also been a much sharper decline in the number of non-UK graduates in this group than is the case for GPs and specialists. A much higher proportion of these doctors are non-UK graduates with 66% being international graduates compared with 39% of specialists and 21% of GPs.

Revalidation

All licensed doctors in the UK have been required to undertake revalidation since 2012 to demonstrate that they are keeping their skills and knowledge up to date. Licensed doctors are expected to undergo an appraisal or check every year, and to collect and reflect on supporting information to demonstrate their competence.⁵⁵ Every five years their responsible officer will recommend to the GMC that the doctor is revalidated, or that the decision is deferred while they gather further evidence or resolve local processes, or that the doctor has failed to engage. Responsible officers have an ongoing responsibility to ensure the doctors connected to them are keeping up with the requirements of revalidation, as well as ensuring that doctors are supported in their practice, including doctors returning to practice with restrictions following a fitness to practise complaint.⁵⁶

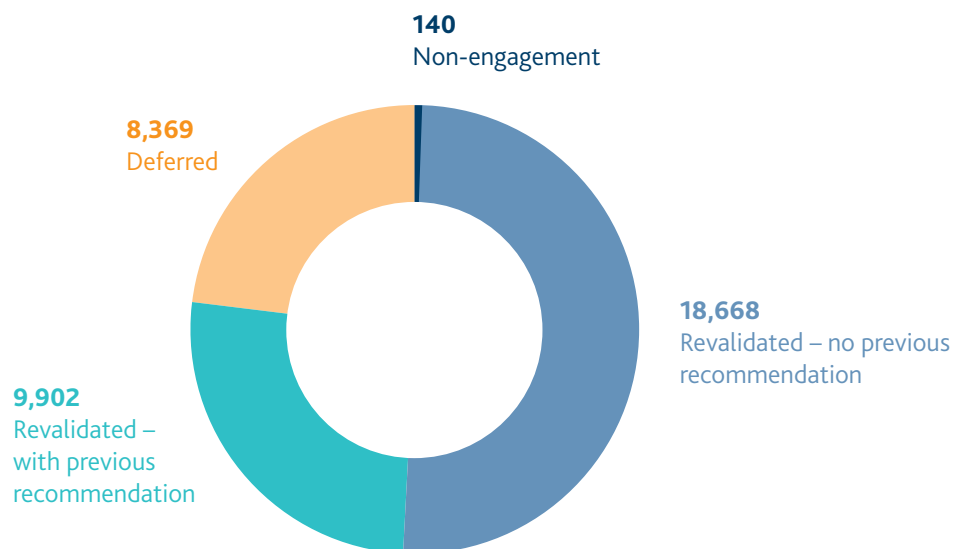
Deferring the decision to revalidate is a neutral act that has no effect on a doctor's licence to practise. This gives the doctor more time to gather and present supporting evidence to demonstrate that they have met the required standards to revalidate. Deferral may be required due to a wide range of circumstances including, for example, a temporary break for health reasons or for maternity leave.

However, while the formal act of deferral is a neutral one, doctors who do not engage in the revalidation process are not engaging in their professional responsibilities and the obligations required of them by their regulator.

In 2016, 37,079 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, for example, deferred and then later in the year revalidated, the final outcomes for these doctors at the end of 2016 were (see figure 18, page 56):

- 28,570 were revalidated, and of these 18,668 had revalidation as their first recommendation in the current revalidation cycle, and 9,902 were revalidated after having a previous recommendation
- 8,369 were deferred to allow them to gather further evidence or resolve local processes
- 140 failed to engage with appraisal or with local systems or processes that support revalidation.

Figure 18: Doctors outcomes of revalidation processes in 2016





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

Summary

This chapter focuses on our data on medical students and doctors in training in the UK. After graduating from medical school, doctors begin two years of foundation training. Doctors are provisionally registered with a licence to practise during their first foundation year and can apply for full registration on completion of this first year.

After two years of foundation training, doctors can apply to enter general practice (GP), core or specialty training. Graduates of non-UK medical schools can join the training programmes at each stage (foundation, core, specialty or GP).

The data relating to medical students are based on figures from 2016 and make comparisons with the previous years from 2012 to 2015. The data used to describe doctors in training are based on figures from 2017 and make comparisons with 2012.

Medical students

- There were 39,185 medical students at UK universities in 2016 compared with 41,422 in 2012, a drop of 5.4%
- The proportion of medical students coming from the UK, Europe and overseas is broadly similar to 2016 in comparison with 2012, though the proportion of students with non-UK nationalities has increased slightly.
- 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%).

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. The number of international medical graduates has decreased by 39.6% since 2012.

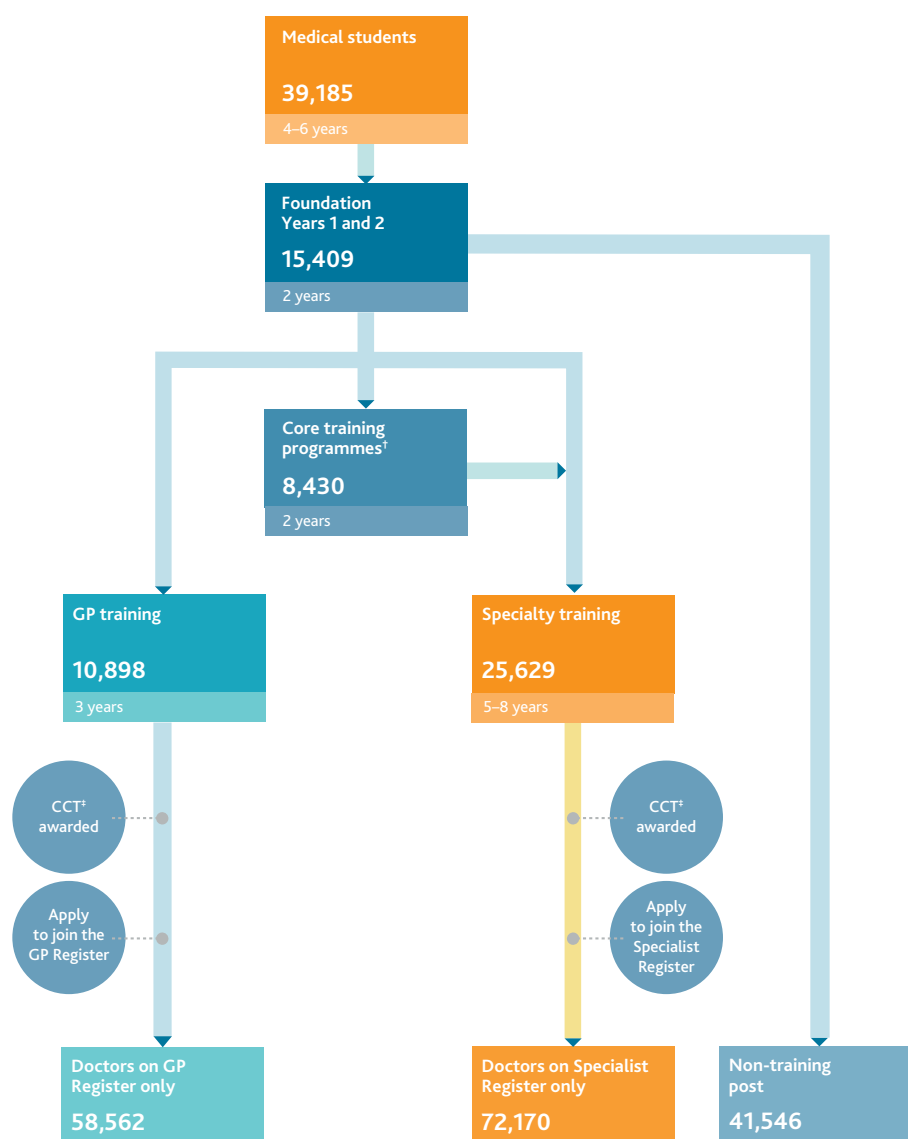
- The GMC has changed the way it records data on ethnicity of doctors in training, enabling more sources of information to be used. This has reduced the number of times ethnicity is not recorded by a quarter. Over a third of UK graduate doctors in training identify as black and minority ethnic (BME).
- The number of doctors in training with a declared disability has increased to 1.93% in 2017 from 0.58% in 2012. This increase could be partly down to the fact that doctors now have more opportunities to provide this information.
- Specialties vary considerably in size. For example there are only 29 doctors in training for sexual and reproductive health in 2017 of which 27 are female. The next lowest number is in intensive care, with 192. The specialty with the highest number of doctors in training is medicine with 7,148.
- Psychiatry has the highest proportion of IMG doctors in training, but its reliance on them is reducing, dropping from 48% in 2012 to 31% in 2017.
- Female doctors continue to make up the majority of all doctors in training in 2017, at 58%, but the growth of female doctors in training under 30 years old continues to slow.
- Almost a third of surgeons in training are female, which is up from a quarter, but surgery has the lowest proportion of any specialty.
- Less than full-time training appears to be most popular in general practice, where more than a third of doctors in training choose it. Monitoring changes in participation of less than full-time training is complex, due to the numbers applying and the numbers approved.

Medical education and training

The pathway that most doctors follow is from medical school into two years of foundation training, with many doctors then going into GP training, specialty training or core training programmes, or they can practise as a doctor

without further training. This is illustrated in figure 19. Doctors who have studied or trained outside the UK may join this pathway at different points or join the register as a fully-qualified doctor.

Figure 19: Medical students and doctors at each stage of medical education in 2016*



* 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).

Medical students

The number of undergraduate students in our UK medical schools has dropped by 5.4% since 2012. There were 39,185 medical students at UK universities in 2016 compared with 41,422 in 2012. This decrease is partly due to a planned reduction in medical school intakes in England since 2013.⁵⁷

The number of male students has fallen by 5.9% and the number of female students has fallen by 5.0% between 2012 and 2016.

However, the numbers of medical students are expected to rise from September 2018 with the announcement that 1,500 additional medical school places will be available per year in England.^{30, 58}

There are more female than male medical students

Medicine is still attracting a higher percentage of female students than male. Women make up 55% of UK medical students compared with men at 45% (see figure 20, page 62).

Medical students in the UK are increasingly diverse

The number of black and minority ethnic (BME) medical students continues to rise steadily (see figure 20, page 62). A quarter identify as Asian or Asian British, 3.3% identify as black or black British, 5% identify as mixed and 3% classed themselves as 'Other'. The number of students identifying as white has dropped from 63.1% in 2012 to 59.3% in 2016. The data collection method for medical students has not changed over that period so we believe these changes reflect the population of medical students.

Figure 20: Number and proportion of medical students by gender and by ethnicity, from 2012 to 2016

	2012		2016
	Number of medical students	% change	Number of medical students
TOTAL	41,422	-5.4%	39,185
Gender			
Male	18,731	-5.9%	17,619
Female	22,691	-5.0%	21,566
Ethnicity			
BME	12,883	11.1%	14,308
White	26,125	-11.0%	23,248
Unknown	2,414	-32.5%	1,629

Medical students in the UK are increasingly international

The number of students identifying as British decreased again in 2016 by 3%, with a total drop of 6.5% since 2012 (see figure 21, page 63).

In 2016 British students made up 87.9% of UK medical students compared with 88.9% in 2012. The number of European students rose

slightly from 2.6% in 2012 to 3.1% in 2016.

Non-European nationality students make up 9% of the medical student population, which is a 6.6% increase from 2015 to 2016 but is similar to the proportion of non-European students in 2012.

Figure 21: Number and proportion of medical students by nationality from 2012 to 2016

	2012		% change	2016	
	% total	Number of medical students		% total	Number of medical students
TOTAL	100%	41,422	-5.4%	100%	39,185
UK	88.9%	36,836	-6.5%	87.9%	34,453
EEA*	2.6%	1,064	14.7%	3.1%	1,220
IMG†	8.5%	3,522	-0.3%	9.0%	3,512

Graduate entry students are more likely to be white and international‡

As many as 3,073 (8%) of those who entered medical school in 2016 had already completed a degree in another subject.

The ethnicity and nationality of these graduate entrants differ slightly from those on standard entry programmes. Almost three quarters (73%) of graduate entry students identify as white compared with 58% on standard entry programmes.

Graduate entry appears to be more appealing to international students than standard entry. 16.6% of graduate entrants are not UK nationals (made up of 4.9% European and 11.6% non-European) while 11.7% of standard entrants are international (3% European and 8.7% non-European). This is an important consideration for workforce planners when looking at ways to attract more people into the medical profession.

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

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

‡ Graduate entrants are students who enter medical school having already completed a degree in another subject.

Doctors in training

When we are reporting on doctors in training we are able to provide data up to 2017, as our data sources are more recent than for medical students where our data rely on submissions from medical schools.

For 2017 there are 60,810 doctors in training, which is a slight increase on the figure we reported in 2016 and an overall increase of 1.7% since 2012. By comparison over the same time period the UK population has expanded by 3.7%.

Doctors in training are more likely to be UK graduates, but are more diverse than the UK population as a whole

Doctors in training are increasingly likely to have gained their primary medical qualification in the UK. Overall the number of UK graduates in training has increased by 11.3% since 2012 (see figure 22, page 65). The number of graduates from the rest of the European Economic Area (EEA graduates) has remained stable since 2012. In 2016 we reported a reduction of international medical graduates (IMGs) in training, and this trend has continued with an overall drop of 39.6% from 2012 to 2017.

The proportion of UK graduate doctors in training who identify themselves as BME is 31% (of those with a known ethnicity), the same as 2012. In comparison with the latest census data for the

UK population in 2011, which showed that 14% of the population in England and Wales are BME, doctors in training are much more ethnically diverse than the UK population.

The slowdown in growth of female doctors in training continues

In our 2016 report we highlighted an overall increase in the proportion of female doctors in training. That trend has continued with female doctors making up 58% of all doctors in training in 2017, up from 57% in 2015.

We also previously described how the historical growth in the number of female doctors in training might be starting to slow. This trend has continued, with a 9% overall reduction in the number of female doctors in training under 30 years old between 2012 and 2017; over the same period male doctors in training of the same age increased by 8%.

The possible reasons for this change are complex, as it may be that more female doctors in training are taking career breaks, and will take longer to complete their training. Tracking the register over a longer period of time will allow us to monitor the extent to which the gender balance is levelling.

Figure 22: Place of primary medical qualification (PMQ), age, gender and ethnicity of doctors in training, from 2012 to 2017

	2012		2017
	Number of doctors in training	% change	Number of doctors in training
TOTAL	59,797	1.7%	60,810
Place of primary medical qualification (PMQ)			
EEA	2,242	4.1%	2,334
IMG	10,939	-39.6%	6,608
UK	46,616	11.3%	51,868
Age group			
20–29	23,949	-3.0%	23,233
30–39	31,437	4.6%	32,877
40–49	4,145	6.4%	4,410
>=50	266	9.0%	290
Gender			
Female	33,039	6.1%	35,048
Male	26,758	-3.7%	25,762
Ethnicity			
White	31,391	13.9%	35,745
BME	20,752	1.7%	21,114
Not recorded	7,654	-48.4%	3,951

Doctors in training aged between 30 and 39 years grew the most

Despite this slowdown, there has been an overall 6% increase in the number of female doctors in training from 2012 to 2017, and a decrease in the total number of male doctors in training.

Compared to 2016, in 2017 there has been an increase of 4% in the number of doctors in training aged between 30 and 39 years. This indicates that doctors in training are taking longer to complete their training, and this may be due to taking career breaks.

Box 3: Changes in the recording of the ethnicity of doctors in training

More doctors in training are disclosing their ethnicity to the GMC. The number of doctors in training whose ethnicity was not recorded reduced by a quarter from 5,279 in 2016 to 3,951 in 2017.

The mechanism for reporting these 'protected characteristics' changed in 2017. In previous years, this was only captured through a question in the national training surveys so those not completing the survey were listed as unknown. In 2017, doctors in training have been able to update their demographic data

when they provide or update their registration details. This means we have more sources to monitor protected characteristics, providing greater accuracy.

As a result, the total number of doctors identifying their ethnicity has increased from 2016 to 2017 in all ethnicities captured: by 2% in doctors identifying as white (59% of all doctors in training); by 14% in doctors identifying as black or black British (4% of all doctors in training); by 3% in doctors identifying as Asian or Asian British (24% of all doctors in training); and by 13% of doctors who identified as 'Other' (3% of all doctors in training).*

Doctors in training with a disability

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

opportunities to provide this information, making our data more accurate. In 2012, 16.1% of doctors in training provided no information as to whether they have a disability compared with 2017's figure of 9.2%.

* In previous years we reported a decrease in the number of Asian doctors in training. It is likely that this is still the case in 2017's data but is being masked by the increased number of doctors deciding to disclose their ethnicity to the GMC. Those doctors were likely always present in the 'Not recorded' category of past editions of *The state of medical education and practice in the UK*.

Training programmes

Changing numbers in training programmes

All doctors leaving UK medical schools need to complete foundation training, and this is reflected in it being the programme with the highest number of doctors at 15,133 (see figure 23, page 68). General practice is the next largest training programme, with 11,051 doctors, an increase of 8.8% since 2012.

Emergency medicine and intensive care medicine have both seen very large percentage increases in doctors in training between 2012 and 2017, though, as we reported in 2016, the increase for

emergency medicine is partly due to changes in the training programme. Radiology and public health have also seen noticeable increases.

Programmes that have experienced a drop in the proportion of doctors in training since 2012 include core training, pathology and psychiatry.

One specialty has very low numbers – there are only 29 doctors in training for sexual and reproductive health. The next lowest is intensive care, with 192.

Figure 23: Changes in the number of doctors in each training programme from 2012 to 2017

	2012		2017
	Number of doctors	% change	Number of doctors
TOTAL	59,797	1.7%	60,810
Foundation	15,041	0.6%	15,133
Core training	8,805	-8.1%	8,089
Anaesthetics	2,928	-6.1%	2,750
Emergency medicine	664	116.6%	1,438
General practice	10,157	8.8%	11,051
Intensive care medicine	60	220.0%	192
Medicine	6,857	4.2%	7,148
Obstetrics and gynaecology	2,349	-7.8%	2,166
Ophthalmology	694	-1.0%	687
Paediatrics and child health	3,688	2.6%	3,783
Pathology	808	-8.4%	740
Psychiatry	1,460	-8.8%	1,331
Public health	253	7.1%	271
Radiology	1,535	13.7%	1,745
Sexual and reproductive health	14	107.1%	29
Surgery	4,484	-5.1%	4,257

Psychiatry still has the highest proportion of international doctors in training

The specialty with the highest proportion of IMG doctors in training is psychiatry, though this has dropped from 48% in 2012 to 31% in 2017.

Public health has the highest number of UK graduates at 95%, followed by intensive care medicine (92%) and anaesthetics (89%). Sexual and reproductive health also has a very high proportion of UK graduates but, as noted previously, the total number for this specialty is extremely small (29 doctors in 2017).

The proportion of surgeons in training that are female has risen sharply but remains the lowest

Most foundation doctors in training are UK graduates (96%) with a higher proportion of women (56% compared with 44% of men).

The proportion of female doctors training in surgery has increased between 2012 and 2017 from 24% to 32% but it remains the training programme with the lowest proportion of women (see figure 24, page 70).

The training programmes with the highest proportions of female doctors are obstetrics and gynaecology (81%), paediatrics and child health (77%) and public health (73%). Sexual and reproductive health also has a high proportion of female doctors in training.

* Full data on this is found in the reference tables available at www.gmc-uk.org/somep2017

Figure 24: Gender of doctors in each training programme from 2012 to 2017

Training programme	Female			Male		
	Number of doctors in training 2012	% change	Number of doctors in training 2017	Number of doctors in training 2012	% change	Number of doctors in training 2017
Foundation	9,006	-5%	8,517	6,035	10%	6,616
Core elements of specialty training	4,622	-8%	4,258	4,183	-8%	3,831
General practice	6,581	15%	7,592	3,576	-3%	3,459
Medicine	3,307	14%	3,770	3,550	-5%	3,378
Surgery	1,086	24%	1,351	3,398	-14%	2,906
Paediatrics and child health	2,575	13%	2,912	1,113	-22%	871
Anaesthetics	1,372	2%	1,398	1,556	-13%	1,352
Obstetrics and gynaecology	1,775	-1%	1,752	574	-28%	414
Radiology	690	22%	843	845	7%	902
Psychiatry	757	8%	820	703	-27%	511
All other programmes	1,268	45%	1,835	1,225	24%	1,522

Less than full-time training

Less than full-time training is increasing, despite a reported decrease between 2016 and 2017

In 2017 the number of doctors who reported training less than full-time has fallen by 11% since 2016 (see figure 25). This is potentially due to changes in the question used to survey doctors in training and analysis of future data collection will allow us to understand this step change better. Similarly, this change may have caused an increased reported number (23%) of doctors in training whose status is unknown between 2016 and 2017.

Less than full-time training is most popular in paediatrics and child health, and least popular in surgery

Within the paediatrics and child health training programme, 20% of those doctors reported being less than full-time; in general practice 17%

did so. The training programme with the lowest proportion of less than full-time working was surgery, which had only 4% (see figure 26, page 72).

Male and female doctors aged 30 to 39 years were more likely to be training less than full-time

15% of female doctors reported that they trained on a less than full-time basis, compared with 2% of males. Unsurprisingly, both female and male doctors aged between 30 and 39 years were more likely to be training on a less than full-time basis, probably due to childcare and other life commitments.*

Figure 25: Reported working patterns of doctors in training each year, from 2012 to 2017

	Number of doctors in training							
Working pattern	2012	2013	2014	2015	2016	2017	2016 to 2017 % change	2012 to 2017 % change
Full-time	47,175	47,879	47,061	46,915	47,516	47,122	-1%	0%
Unknown	8,532	7,679	6,409	6,818	6,543	8,047	23%	-6%
Less than full-time	4,090	4,797	6,006	6,202	6,307	5,641	-11%	38%

* A full breakdown of data about doctors in training who were in less than full-time training between 2012 and 2017 is available in the reference tables at www.gmc-uk/somep2017

Figure 26: Reported working patterns for the ten largest training programmes from 2012 to 2017

PROGRAMME SPECIALTY GROUP	2012	2017
Working pattern	Number of doctors in training	Number of doctors in training
FOUNDATION		
Full-time	14,014	14,320
Unknown	745	593
Less than full-time	282	220
CORE ELEMENTS OF SPECIALTY TRAINING		
Full-time	7,546	7,135
Unknown	880	542
Less than full-time	379	412
GENERAL PRACTICE		
Full-time	7,788	7,760
Unknown	1,335	1,368
Less than full-time	1,034	1,923
MEDICINE		
Full-time	4,251	4,470
Unknown	2,009	1,988
Less than full-time	597	690
SURGERY		
Full-time	3,342	3,296
Unknown	956	800
Less than full-time	186	161
PAEDIATRICS AND CHILD HEALTH		
Full-time	2,430	2,334
Unknown	717	698
Less than full-time	541	751
ANAESTHETICS		
Full-time	2,089	1,965
Unknown	569	383
Less than full-time	270	402
OBSTETRICS AND GYNAECOLOGY		
Full-time	1,684	1,311
Unknown	441	519
Less than full-time	224	336
RADIOLOGY		
Full-time	1,179	1,303
Unknown	197	228
Less than full-time	159	214
PSYCHIATRY		
Full-time	1,047	882
Unknown	227	233
Less than full-time	186	216
ALL OTHER TRAINING PROGRAMMES		
Full-time	1,805	2,346
Unknown	456	695
Less than full-time	232	316



3 Complaints about doctors

Summary

Complaints or concerns about a doctor's fitness to practise come from a variety of sources. Between 2011 and 2013 we saw a sharp increase of 22% in complaints and then a decline of 9% between 2013 and 2015, partially reversing that surge. In 2016 the level of complaints was similar to 2015, falling 1% but still 10% above the level in 2011.

- The largest proportion of complaints is from the general public and these accounted for nearly 70% of the total in 2016. The rise in complaints to 2013 and the subsequent fall therefore largely reflected a surge in complaints from the public that then diminished, the reasons for which are unclear.
- The number of concerns raised with the GMC by doctors' employers has fallen each year since 2013 and particularly sharply in 2016, down 35% from 2015. This may reflect, since the introduction of revalidation, the impact of responsible officers helping to resolve and prevent more issues locally, supported by the GMC's Employer Liaison Service (ELS).
- This is in part the result of the introduction of provisional enquiries that provide us with more information than previously to judge whether a case needs a full investigation. Provisional enquiries are limited enquiries, which take place at the triage stage of the fitness to practise process, and are designed to help us decide whether to close a complaint, or to open a full investigation. Since these were introduced at the end of 2014 this has avoided the need for about 700 full investigations.

Each full investigation is assigned an allegation type, and the proportion of each allegation type has not changed greatly between 2011 and 2016, although there has been a small decline in the proportions concerning a doctor's health or criminality.

The proportion of complaints from all sources leading to full investigations has dropped between 2011 and 2016, with an overall fall in the number of full investigations from 2,265 in 2011 to 1,436 in 2016.

- Between 2014 and 2016 the fall in the number of full investigations has been particularly sharp, especially in the case of complaints from the public.

There has been a reduction in the number of sanctions and warnings given to doctors in 2016 compared to 2015. The number of suspensions or erasures was down by 8%, from 191 in 2015 to 176 in 2016. There was a 12% fall in the number of doctors receiving conditions or undertakings, and a 31% fall in the number of doctors receiving warnings.

Complaints about a doctor's fitness to practise

Complaints or concerns about a doctor's fitness to practise are raised with the GMC from a variety of sources. These are collectively referred to as complaints. They lead to one of three initial decisions:

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

If a full investigation is undertaken, this may lead to no further action or to a range of outcomes such as a sanction or a warning being given to the doctor.

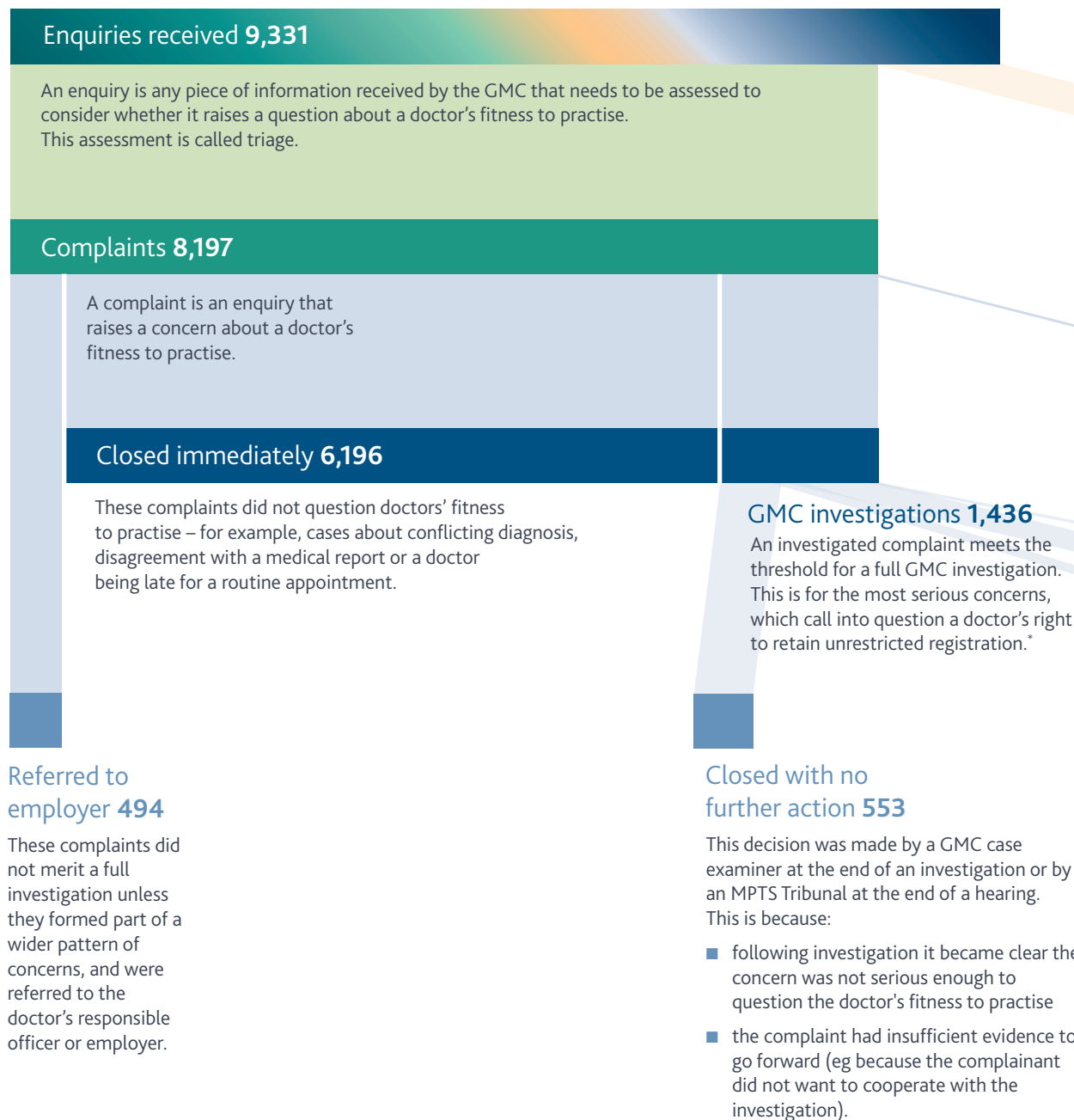
This process is summarised in figure 27, page 76–77. It shows that of the complaints received in 2016, 18% (1,436) were investigated, 6% (494) were sent back to employers for further examination and 76% (6,196) were closed immediately.*

Of those that led to full GMC investigations, 50% were closed with no further action or a letter of advice, 3% resulted in a warning and 3% in a sanction. The remaining 45% were still in progress as of 31 May 2017.

This chapter looks at the changing volume of complaints, investigations and outcomes in more detail. We first consider the flow of complaints into the GMC. We then look at the likelihood of complaints from different sources leading to a full investigation and the impact changes in our fitness to practise processes have had on the number of full investigations. Finally we look at trends in the outcomes of full investigations.

* A small number of cases (71) were still being triaged on 31 May 2017 when the data were extracted.

Figure 27: How the GMC handled enquiries received about doctors in 2016



* 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.

* In most cases, case examiners are able to issue a warning or agree an undertaking with the doctor after the investigation. In some cases decisions to impose a sanction will be taken by the MPTS tribunal.

Enquiries not about a doctor's fitness to practise **1,134**

Enquiry still open **71**

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 **168**

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

Still being investigated **640**

These complaints were unresolved on 31 May 2017.

Sanction or warning given **75**

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 **36**

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 **35**

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 **4**

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

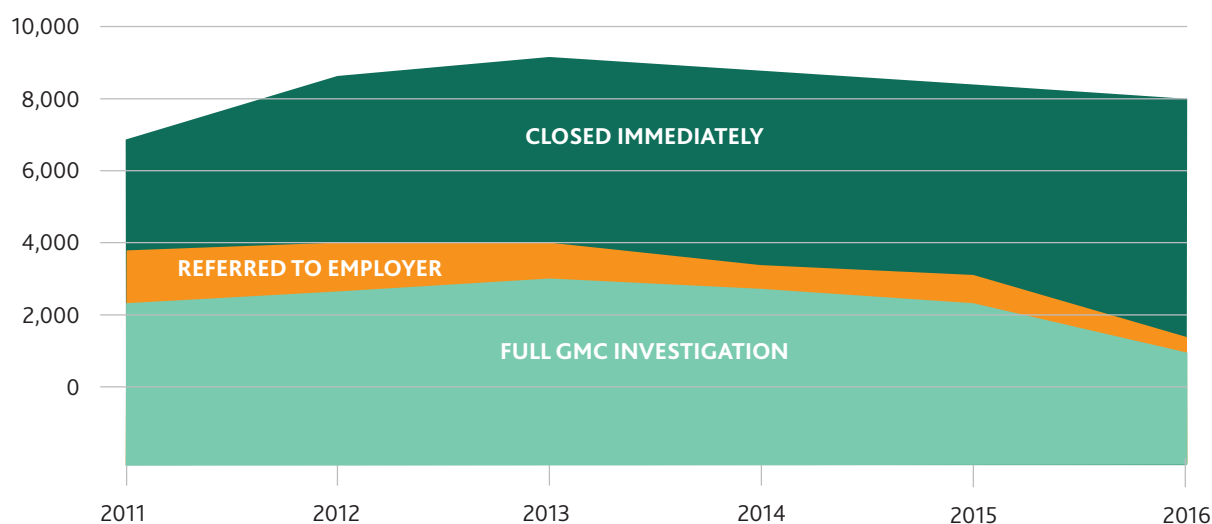
Trends in the number of complaints

Fewer complaints are being made about doctors, but the drop in complaints has slowed

The number of complaints increased between 2011 and 2013, growing by 22%. After this point

the volume reduced gradually to 2016. The 8,197 complaints received in 2016 were 10% lower than the peak in 2013 (9,062) (see figure 28).

Figure 28: Numbers of complaints, investigations and closures, from 2011 to 2016*



The overall volume of complaints is driven by complaints from the public

The GMC receives complaints from a wide range of sources (see figures 29 to 31, pages 80–81), but the vast majority – 69% in 2016 – came from the public. The large increase in overall complaints between 2011 and 2013 and the large decline in 2014 and 2015 were largely driven by changes

in the volume of complaints from the public. The reasons behind this are unclear. In 2016, the decline in complaints from the public came to an end with a very slight rise of just under 1%. This was the main reason for the slowdown in the decline of overall complaints in 2016.

* Overall, the GMC received 9,331 enquiries in 2016. Of these, 88% related to a doctor's fitness to practise and became a complaint.

Doctors are increasingly raising concerns

Cases opened by the GMC include those coming from media coverage. These increased up to 2012, and then reduced. Fewer of these are now investigated, potentially due to improved communication between the GMC and employers resulting in a better understanding of the issues before deciding whether there is a need to open a case.

Apart from the GMC's own initiation of complaints the largest increase in complaints in 2016 came from doctors raising concerns about other doctors (up from 753 in 2015 to 829 in 2016). Although there is some variation year to year there has been a large increase during the period 2013 to 2017 from less than 600 a year in 2011 and 2012. This may relate to the emphasis in recent years in trying to ensure that doctors feel able to raise concerns, reinforced through the *Duty of candour* guidance in 2015.*

Although the number of doctor self-referrals from doctors concerned about their health, referring criminal investigations or convictions, or raising concerns they may have breached fitness to practise standards—has increased between 2011 and 2016 it gradually reduced between 2014 (524) and 2016 (450).

The number of complaints from employers reduced sharply in 2016

In 2016 the number of complaints from employers fell by more than a third in a single year from 528 in 2015 to 345 in 2016. Complaints by employers have been reducing since 2012 but this is the single largest reduction seen in that time. The decline may in part be due to the positive impact of responsible officers helping to resolve and prevent more issues locally supported by the ELS which was introduced as a pilot in 2010 and rolled out in 2012.

After the ELS was introduced, the number of complaints from employers initially rose as employers and doctors began engaging with the ELS and the impending introduction of revalidation encouraged employers to clear any outstanding activity that may have warranted referral to the GMC. After that initial increase, employer referrals dropped down again during the period from 2013 to 2016 (see figure 31, page 81) as the ELS helped ensure complaints were handled locally where appropriate.

* Our updated guidance is available at http://www.gmc-uk.org/guidance/ethical_guidance/27233.asp

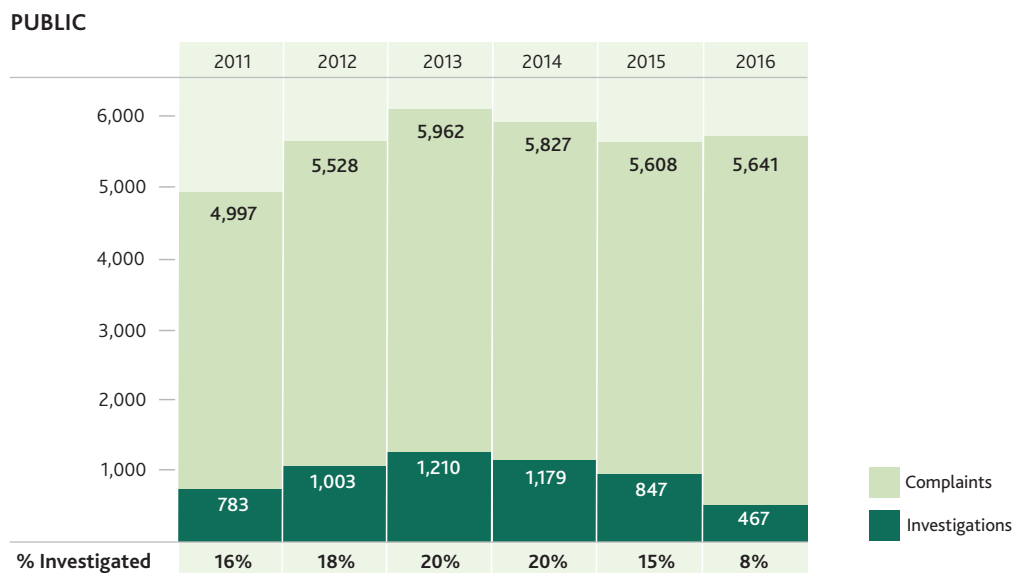
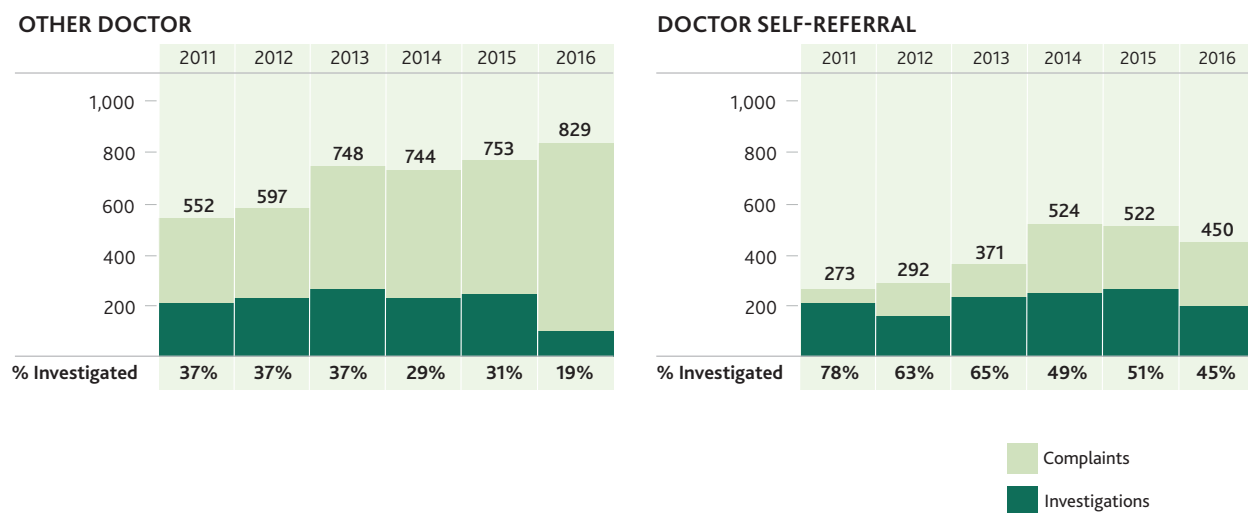
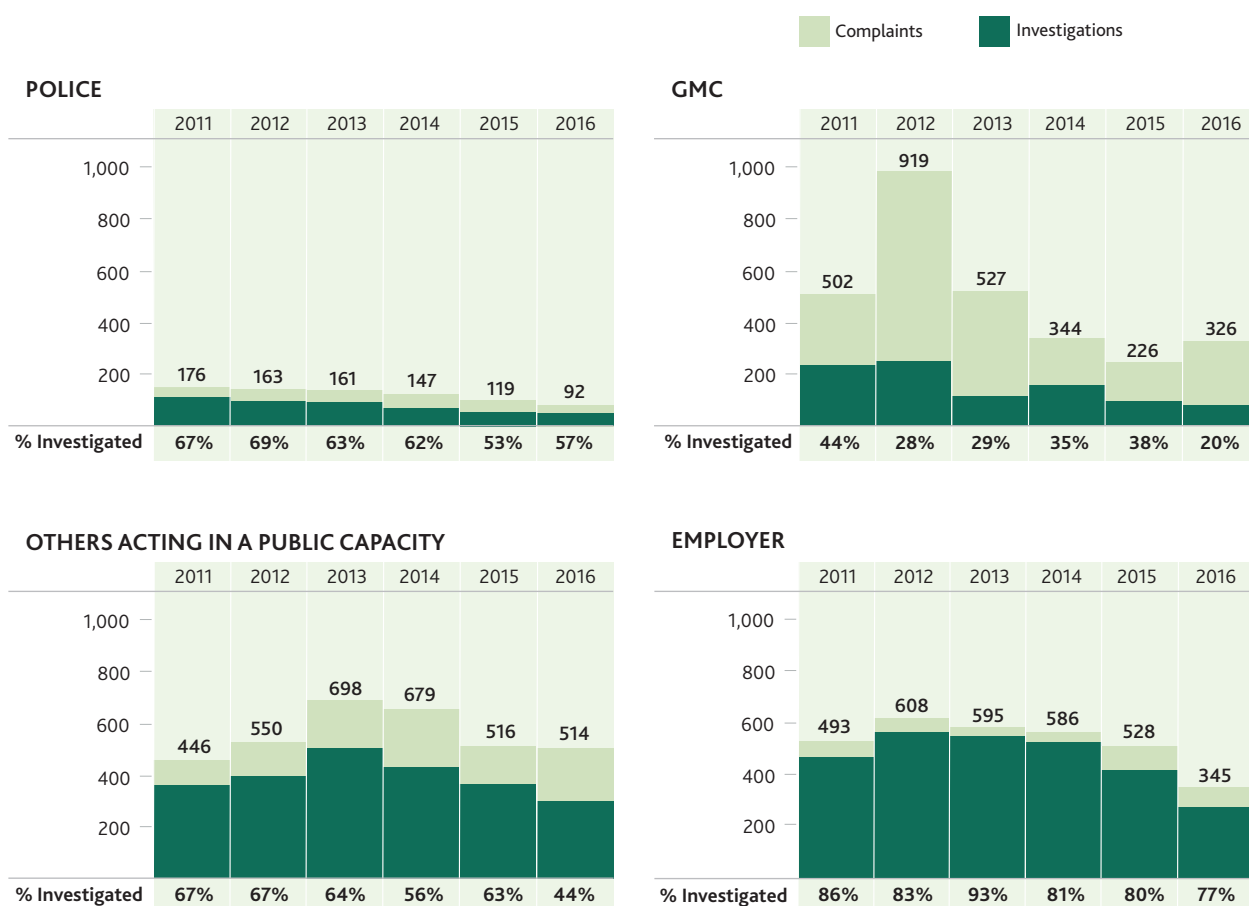
Figure 29: Number of complaints and full investigations from the public, from 2011 to 2016**Figure 30:** Number of complaints and full investigations from the profession, from 2011 to 2016

Figure 31: Number of complaints and full investigations from institutions, from 2011 to 2016

The proportion of complaints fully investigated is falling

The proportion of complaints fully investigated has fallen significantly over the period 2011 to 2016 for all sources of complaint as shown in figures 29 to 31. Apart from a tiny rise in the proportion of referrals from the police being fully investigated, an overall fall in complaints fully investigated is evident in 2016 compared with 2015, with a particularly steep fall that year in the proportion of complaints from the public that were fully investigated – down nearly a half from 15% to 8% in a single year. This is partly down to concerted action to handle fitness to practise issues and complaints more efficiently and effectively (see box 4, page 83).

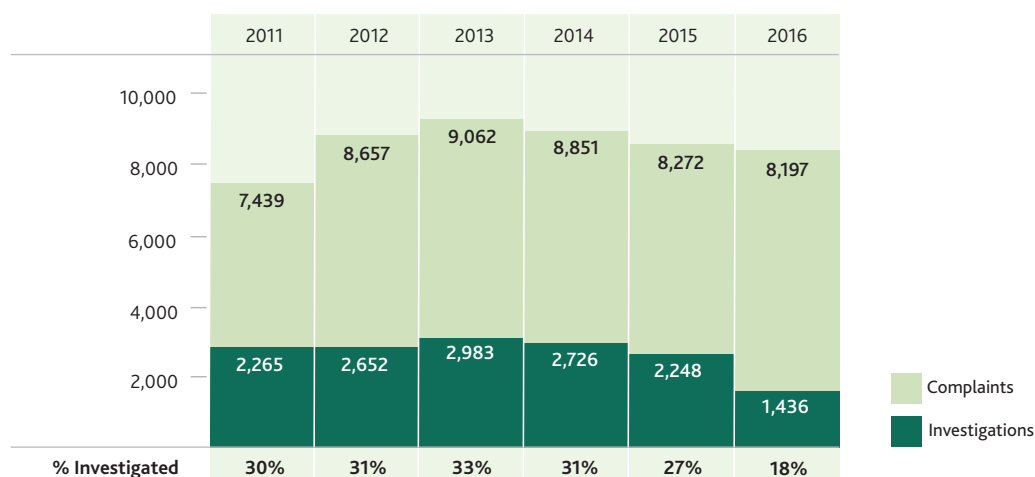
A higher proportion of concerns raised by employers were fully investigated compared with complaints from other sources. These too have seen a fall in recent years from a peak of 93% in 2013 to 80% in 2015 and 77% in 2016.

The result is that there has been a 37% fall in the overall number of full investigations from 2,265 in 2011 to 1,436 in 2016. There has been a particularly steep fall since 2013 with the proportion of complaints fully investigated falling from 33% to 18% (see figure 32, page 82).

The corollary of this reduction in the number of full investigations has been an increase in the number of complaints closed immediately. In 2016

this rose by 14% to 6,196, from 5,458 in 2015. This is 68% higher than in 2011.

Figure 32: All complaints and proportion that were fully investigated, from 2011 to 2016



Changes in the way we handle complaints account for much of the fall in the number of full investigations

The GMC continues to improve the way it handles complaints as outlined in box 4 on page 83. One aim has been to ensure that where a complaint does not require a full investigation we are able to deal with it as quickly as possible. This is not only more efficient, but contributes alongside other actions we are taking to reduce the stress of the process for the doctors and complainants involved.

To this end provisional enquiries were introduced in November 2014. These involve us asking additional questions before deciding if the threshold for a full investigation is met. Prior to this these cases would have entered the full investigation process before this information was obtained.

The number of provisional enquiries has gradually increased during the period from 2014 to 2016 as the process was rolled out across the types of complaint identified as being most suitable. This improvement in process has accounted for much of the fall in the proportion of complaints for which we launch a full investigation.

Overall, 4.5% of complaints about doctors in 2015 and 6.9% in 2016 were subject to a provisional enquiry. Since their introduction 1,001 complaints have had provisional enquiries. Figure 33 on page 83 shows that nearly 700 of these complaints have been closed without a full investigation being necessary. Just over a quarter (28%) of these have subsequently required a full GMC investigation, meaning nearly three quarters of provisional enquiries avoid the need for a full investigation (72%).

Figure 33: Number and outcome of provisional enquiries received up to 2016

End result of provisional enquiry	Number of provisional enquiries			2014–16 Overall
	2014*	2015	2016	
Full GMC investigation	16	90	171	277
Referred to employer	–	9	2	11
Closed immediately	44	276	377	697
Still being assessed	–	–	16	16
Total	60	375	566	1,001

Since its introduction, provisional enquiries have reduced the number of full GMC investigations by 708

Box 4: The GMC continues to reform its processes for handling complaints about doctors

Since 2010 the GMC has continued to improve the way it handles complaints about doctors.

The introduction of the Employer Liaison Service pilot in 2010, rolled out in 2012, has facilitated closer working between the GMC and the employers of doctors, focusing on matters related to fitness to practise and the revalidation of doctors.

In June 2012 the Medical Practitioners Tribunal Service (MPTS) was established to provide a clear separation between the GMC's investigation function and the adjudication of hearings.

Provisional enquiries were introduced in November 2014 as a pilot, and then rolled out more widely. These involved us asking additional questions to better understand the severity of allegations before deciding if the

threshold for a full investigation was reached. From its inception to the end of 2016, over 700 investigations had been avoided through provisional enquiries finding that no full GMC investigation was required. We are currently piloting an expansion of provisional enquiries to include incidents where a doctor has made a one-off mistake involving poor clinical care. The provisional enquiry will help identify cases without an ongoing risk to patients, and cases where a doctor has taken steps to make sure it will not be repeated. In these cases a full investigation by the GMC would not usually be required.

In December 2015 we introduced new powers to manage doctors who fail to comply with an investigation, together with a right of appeal against MPTS decisions, to enhance patient protection.

* Introduced as a pilot in November 2014, only 60 cases were given provisional enquiry in 2014.

Also in 2015, after a successful pilot in 2012, the GMC introduced the Doctor Liaison Service to improve the way we encourage doctors to share information with us at an earlier stage. By obtaining information earlier, we can better identify whether a hearing is needed and facilitate early resolution in some cases.

In the same year, we introduced the Patient Liaison Service to make sure patients understand what happens after they have made a complaint about a doctor, to give them an opportunity to explain their concerns fully, so they can be sure we have understood, and to improve their understanding of the fitness to practise process.

The BMA were commissioned by the GMC to run the Doctor Support Service,⁵⁹ which was introduced in 2015 to provide free, independent and confidential emotional support for any doctor that is under investigation. Being investigated by the GMC can be a stressful experience, and this service provides the opportunity for doctors to talk in confidence about this. We provide a similar service for patients who have made a complaint.

A significant programme of reform was announced in 2016 to reduce the stress of

the fitness to practise process on doctors, following work with Professor Louis Appleby, a leading mental health expert, to review the impact of these procedures on vulnerable doctors. Changes include the introduction of a single point of contact for a doctor under investigation, coordination of our communication with doctors we are investigating, and mental health awareness training for GMC staff.

A second pilot introduced in 2016 takes forward one of the recommendations of Sir Anthony Hooper's review for the GMC of whistleblowers in our procedures. It will require designated bodies, such as NHS organisations and independent healthcare providers, to disclose whether the doctor who is being complained about to the GMC has previously raised any patient safety issues. The person referring the concerns will also have to make a declaration that the complaint is being made in good faith, and that steps have been taken to make sure it is fair and accurate. This will help the GMC to assess whether a full investigation is necessary, and will help to reduce the risk of doctors who have acted as whistleblowers subsequently being disadvantaged.

What full investigations are about is changing

As cases are fully investigated, the precise nature of the allegations involved becomes clearer and we record these allegations in each full investigation. Every case is unique and may involve a single allegation or different combinations of allegations. We define over 300 allegations related to a

doctor's possible failure to meet the standards expected of them. To help analyse the different types of cases, we have defined ten broad groups of allegations in box 5, on page 85. More information on these groups can be found in the 2016 edition of this report.⁴

Box 5: Allegation types 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 impact of a doctor's physical or mental health on their fitness to practise, 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 third, fourth and fifth 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.

The number of full investigations is decreasing, and the relative decrease is greatest for allegations relating to the impact of a doctor's health on their fitness to practise

The drop in the overall number of investigations reflects fewer investigations in all the types of allegations (see box 5, page 85). All types

of allegations are now less likely to reach investigation (see figure 34) but the largest relative decrease was in allegations about a doctor's health (-61%), followed by all criminality but not health (-58%).

Figure 34: Number of full GMC investigations by allegation type, from 2012 to 2016

	2012		% change	2016	
	% total	Number of doctors		% total	Number of doctors
TOTAL	100%	2,265	-37%	100%	1,436
Doctor's health	11%	245	-61%	7%	96
All criminality, but not health	15%	332	-58%	10%	139
Honesty or fairness (only)	13%	284	-43%	11%	163
Honesty or fairness, but not health, criminality or competence	5%	124	-32%	6%	84
Honesty or fairness and clinical competence	3%	68	-12%	4%	60
Clinical competence (only)	18%	410	-52%	14%	195
Clinical competence and communication and respect	7%	165	-56%	5%	72
Communication and respect (only)	2%	54	-26%	3%	40
Professional performance but not health or honesty or probity	22%	509	-40%	21%	305
Other combinations of allegations*	3%	74	281%	20%	282

* Cases with no allegation type recorded are often are still under investigation, are included in the 'Other combinations of allegations'. These cases account for 11 out of 74 in 2012, and 191 out of 282 in 2016.

What were the outcomes of cases concluded in 2016?

Some full investigations opened in 2016 will still be ongoing so their outcome is still unknown. This makes it impossible to assess trends in outcomes on the basis of full investigations opened. In this section therefore, the data refer to

cases closed during the six-year period 2011–16 irrespective of when the complaint was received.

A full investigation may lead to a number of outcomes as described in box 6.

A note on data

Data presented here show the number of cases concluded in 2016. The year in which a case concludes is often different from the year the complaint was received due to the time it takes to handle. This means that the number of cases concluded differs from the number of complaints received each year, and the

data presented in this section are not directly comparable with the data presented elsewhere in this chapter or in chapter 4. For example, 176 cases were closed with suspension or erasure in 2016, but only four of those (listed in figure 27, on page 76) were from cases received in 2016.

Box 6: Possible outcomes from full investigations

Following an investigation by our case examiners, a decision is made to determine whether the case can be closed or whether the doctor's fitness to practise may be impaired. If it is, the case may be referred for further consideration by an MPTS tribunal.

There are a number of sanctions and outcomes through this overall process.

- The doctor may be erased or suspended from the medical register, preventing them from working as a doctor in the UK.
- If the doctor can safely continue practising with appropriate support, supervision or re-training, they will be given conditions or undertakings.
- If the doctor is fit to practise, but there is evidence of a significant breach of professional standards that they should reflect on, 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.

Between 2011 and 2016 the number of full investigations concluded each year reduced by 7.6% (figure 35, page 89), with an increase from 2,179 in 2011 to a peak of 2,823 in 2015 before dropping back down to 2,014 in 2016.

Of these investigations concluded in 2016:

- 63% were closed with no further action (1,261)
- 17% were closed with advice given to the doctor (334)
- 5% resulted in warnings (96)
- 7% resulted in conditions or undertakings (147)
- 9% resulted in suspension or erasure (176).

The proportion and number of full investigations closed with no further action dropped significantly between 2015 and 2016

Investigations that resulted in no further action increased from 919 in 2011 to 1,943 in 2015 (see figure 35, page 89), before dropping markedly in 2016 as the GMC's reform programme and use of provisional enquiries took effect (see box 4, pages 83–84).

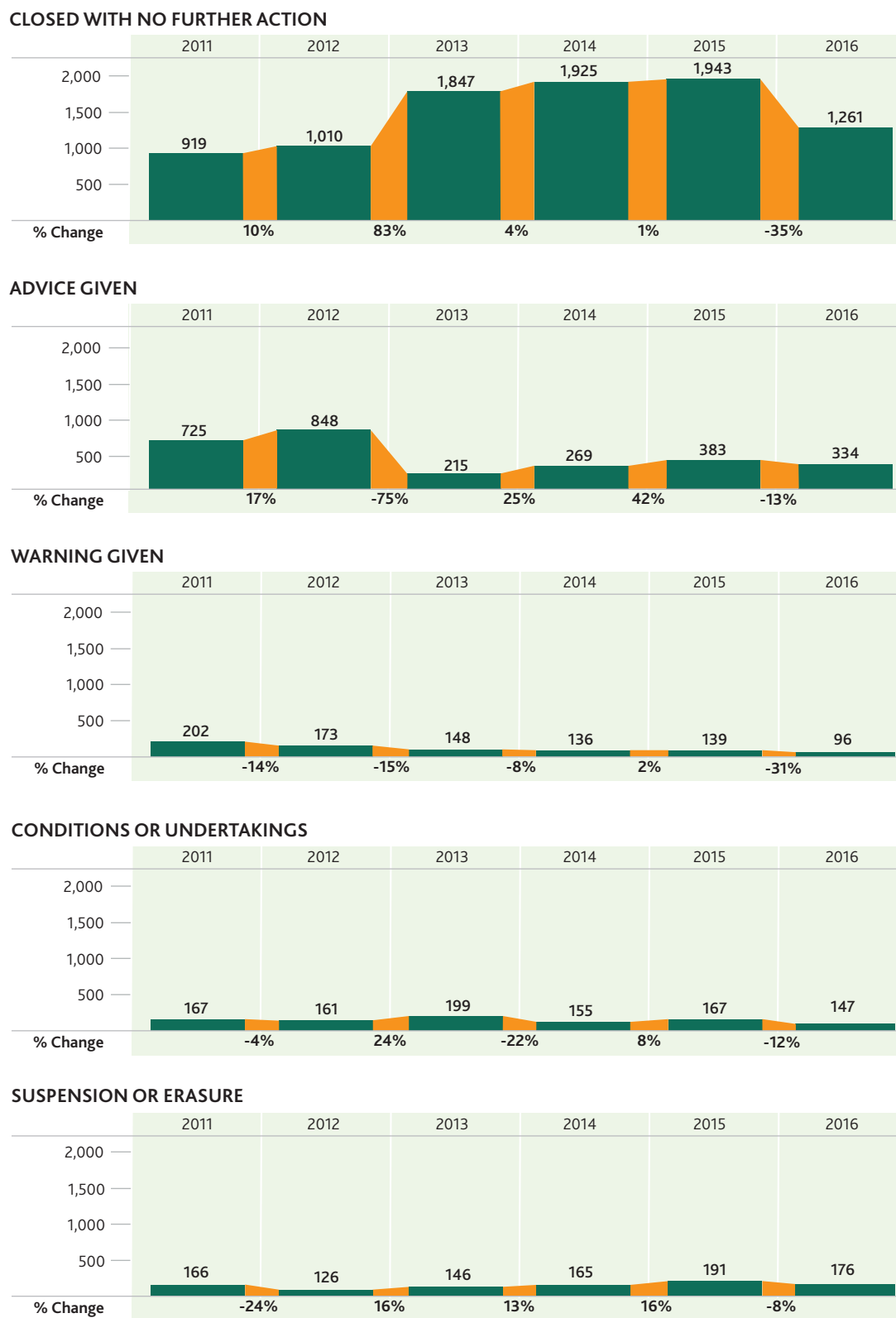
The number of full investigations resulting in advice decreased after 2012

Between 2012 and 2013 the number of full investigations leading to advice reduced due to the GMC changing its process for issuing advice, as we reported in previous versions of this report.⁶⁰

The number of warnings has decreased between 2011 and 2016, while the numbers of different sanctions have fluctuated but remained fairly constant overall

The number of warnings given has reduced from 202 in 2011 to 96 in 2016. Over the same time period, the numbers of each sanction (conditions, undertakings, suspensions and erasures) have remained relatively constant, though numbers vary greatly from year to year.

Figure 35: Number and annual change of investigation outcomes per year, 2011 to 2016



Investigations resulting in the most serious outcomes were most likely to have been referred by employers

The number of full investigations concluded that lead to the most serious sanctions of suspension or erasure is small, and fluctuates from year to year. Full details of the data are available in our reference tables so are not repeated here.* When we look at the 2011 to 2016 period as a whole there is a clear pattern (see figure 36) in relation to the source of complaints that lead ultimately to a suspension or erasure.

Over a third (37%) of all suspensions and erasures were from concerns raised by employers, and only just over one in ten were from complaints by the public (11%) despite the public accounting for nearly 70% of complaints received by the GMC.

As we have reported in previous years, we see this pattern in part due to employers being more likely than the public to refer doctors with allegation types that lead to more serious outcomes.†

Figure 36: Proportion of erasure or suspension outcomes by source of complaint, from 2011 to 2016

Suspension or erasure	2011–16 Overall
Public	11%
Employer	37%
Other doctor	8%
Doctor self-referral	7%
Police	9%
GMC	6%
Others	22%

* Reference tables of data are available at www.gmc-uk.org/somep2017

† For more detailed analysis of this ongoing pattern see *The state of medical education and practice 2016*, pages 76 to 80.

4

Groups of doctors with higher rates of complaints and investigations

Summary

In this chapter we consider which groups of doctors had a higher rate of being complained about, having their complaints investigated and receiving sanctions or warnings.

In the five-year period from 2012 to 2016, only about one in ten doctors were complained about, and one in 100 received a sanction or a warning.

Even in groups with a higher rate of receiving a sanction or a warning from the GMC, the vast majority do not receive these. Therefore even in groups of doctors with double the rate of others, only a very small minority are subject to sanctions or warnings. Although the numbers are small, we still need to understand where the risk of a sanction or a warning is heightened to investigate further the causes of this and determine whether there is an intervention that could reduce the risks to patient safety.

The 2016 data we have added this year have not changed the broad conclusions we reached previously. In very broad terms:

- GPs are more complained about than other doctors – particularly by members of the public, which is not surprising given the number of patient interactions. But complaints about doctors not on the Specialist or GP Register and not in training are considerably more likely to reach the threshold for a GMC investigation and lead to a sanction or a warning. This means that double the proportion of these doctors ultimately receive a sanction or a warning compared with specialists, with GPs about halfway between the two.
- Male doctors tend to receive proportionately more sanctions or warnings than their female counterparts working in similar areas and the same is true of older doctors relative to those under 50 years old.
- Those who graduated outside the UK tend to receive proportionately more sanctions or warnings than UK graduates. Among UK graduates non-specialist doctors identifying as black and minority ethnic (BME) tend to receive proportionately more sanctions or warnings than those identifying as white, whereas for specialists the rate is similar.
- Among the larger specialty groups, those in obstetrics and gynaecology, surgery, and psychiatry receive proportionately more sanctions or warnings.

These factors of a doctor's characteristics and role in combination create some specific groups with higher rates of receiving a sanction or a warning and we have highlighted them in this chapter.

Some of the differences in the rates of complaints, investigations and sanctions or warnings between groups relate to the fact that some groups get more complaints about them

from particular sources compared to other groups, and that some groups have more concerns raised or complaints made about them relating to specific areas than other groups.

- About a quarter of concerns raised by employers or the police and via self-referrals in 2012 to 2016 have so far resulted in sanctions or warnings (a very small proportion of cases are still in progress).

The equivalent figure for complaints made by the public is one in a 100.

- Over half of cases concerned with a doctor's health, and over a third of cases involving probity or criminality, result in a sanction or a warning. This contrasts with cases involving only clinical competence, where only about one in 20 end in a sanction or a warning.

Complaints and investigations – the overall numbers

In this chapter we examine the type of doctors who are complained about, have the complaint investigated and receive sanctions or warnings, and the source of these complaints.

One in ten doctors complained about but less than one in a 100 doctors on the register received a sanction or a warning in the five-year period from 2012 to 2016

Over the five-year period from 2012 to 2016, 10% of doctors were complained about. This is equivalent to about 3% each year, including the small number complained about in more than one year.

In the same five-year period, 3.5% were investigated. Less than one in a 100 doctors (0.6%) received a sanction or a warning (see figure 37, page 94).

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 prevalence than others.

The data in this chapter show the rate of a complaint, investigation, or a sanction or a warning for the five-year period from 2012 to 2016. The prevalence of being complained about increases the more years are added together.

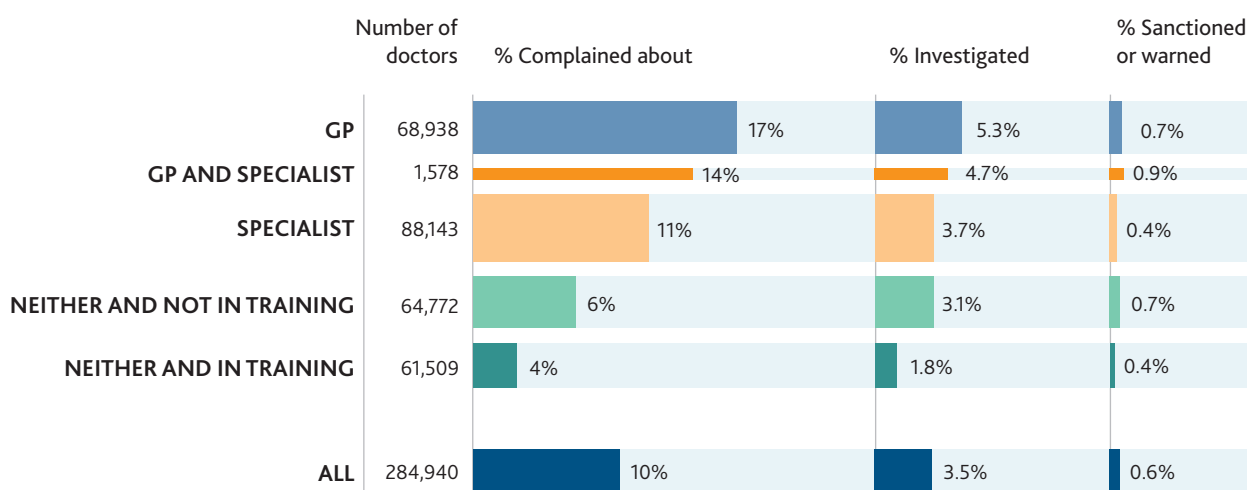
At the time of publication we have only partial data about complaints for 2017, so have not included that year in our analysis.

Complaints about doctors

In this chapter we analyse the rate of complaints and investigations by looking at the characteristics of the doctors who have received complaints against them. Some doctors were complained about more than once and in these cases the complaint with the most serious outcome is selected for analysis.

In the previous chapter we looked at the volume of complaints received by the GMC. In this chapter we look at the number of doctors complained about, which results in smaller numbers as doctors with multiple complaints are only counted once.

Figure 37: The proportion of doctors complained about, having a complaint investigated, and receiving a sanction or a warning, by register, from 2012 to 2016

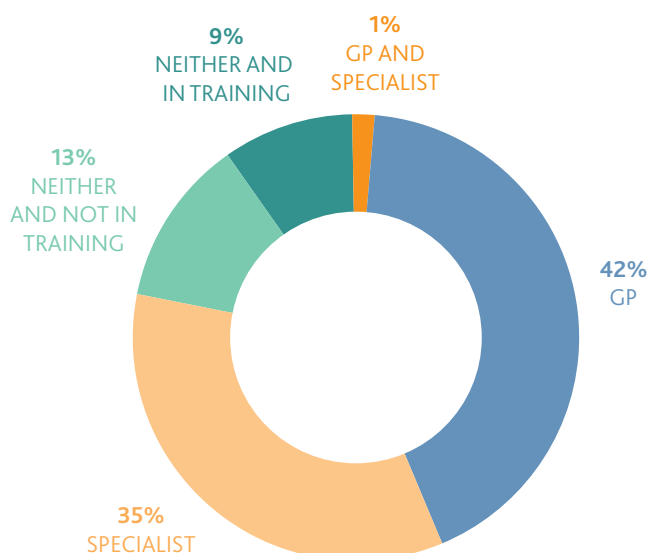


Doctors on neither the GP nor the Specialist Register and not in training have double the sanction/warning rate of specialists

The percentage of doctors complained about, having a complaint investigated, and receiving a sanction or a warning varies by register type. Almost one in five (17%) GPs were complained about compared with one in eight (11%) specialists and only one in 20 (5%) those on neither.

The complaints received about doctors on neither the GP nor the Specialist Register were, however, more likely to reach our threshold for investigation and receive a sanction or a warning than complaints about other doctors (see figure 39, page 96). As a result, despite a lower proportion being complained about, doctors on neither the Specialist nor GP Register who are not in training had the highest rate of receiving a sanction or a warning and double that of specialists: 0.7% compared with 0.4% for specialists.

Because GPs are more likely to be complained about than other doctors, they account for over

Figure 38: The proportion of all complaints received, by register type, from 2012 to 2016

two fifths of all complaints (42%), even though they make up only about a quarter of all doctors. Specialists account for a third of all complaints (35%) while doctors who are on neither the GP nor the Specialist Register receive about a fifth (22%) (see figure 38).

Most doctors complained about do not meet the threshold of a GMC investigation and most investigations did not result in a sanction or a warning

Being complained about does not necessarily result in an investigation. Nearly two thirds of complaints (63%) between 2012 and 2016 did not result in such an outcome.

The percentage of complaints investigated varied by type of doctor, complaints about doctors not on the GP or Specialist Register were most likely to be investigated: 55% of those not in training and 46% of those in training compared with

34% of complaints about specialists and 32% of complaints about GPs.

Of the doctors investigated between 2012 and 2016, over four fifths (84%) did not end up with a sanction or a warning. Again, investigations about doctors not on the Specialist or GP Register were more likely to end with a sanction or a warning: 24% of those about doctors who were not in training and 23% of those in training, compared with 13% of investigations about GPs and 12% of investigations about specialists (see figure 39, page 96).

Specialists in occupational medicine and psychiatry are most complained about, and surgery has the most sanctions or warnings

Doctors on the Specialist Register have different rates of being complained about depending on their specialty group.

Complaints: Around one in five specialists qualified in the occupational medicine and psychiatry specialty groups were complained about in the five years from 2012, compared with about one in 20 of specialists in pathology, public health, anaesthetics, and intensive care medicine.

Investigations: Nearly half of complaints in obstetrics and gynaecology reached our thresholds for investigations, higher than in other areas. They were also the most investigated – 7.6% compared with 5.9% of those in surgery, 4.5% of those in occupational medicine and 3.9% of those in psychiatry. Of the larger specialist

groups, those in anaesthetics and intensive care medicine were the least investigated.

Sanctions or warnings: The rate of sanctions or warnings is broadly similar across specialty groups: it was slightly higher for doctors working in obstetrics and gynaecology, and in surgery, the second largest specialty. Over 0.6% of doctors working in these areas received a sanction or a warning, double the 0.3% of those with a specialty in medicine, the largest specialty (see figure 40, page 97).

Figure 39: Number of doctors complained about, investigated, and sanctioned or warned, by register type, from 2012 to 2016

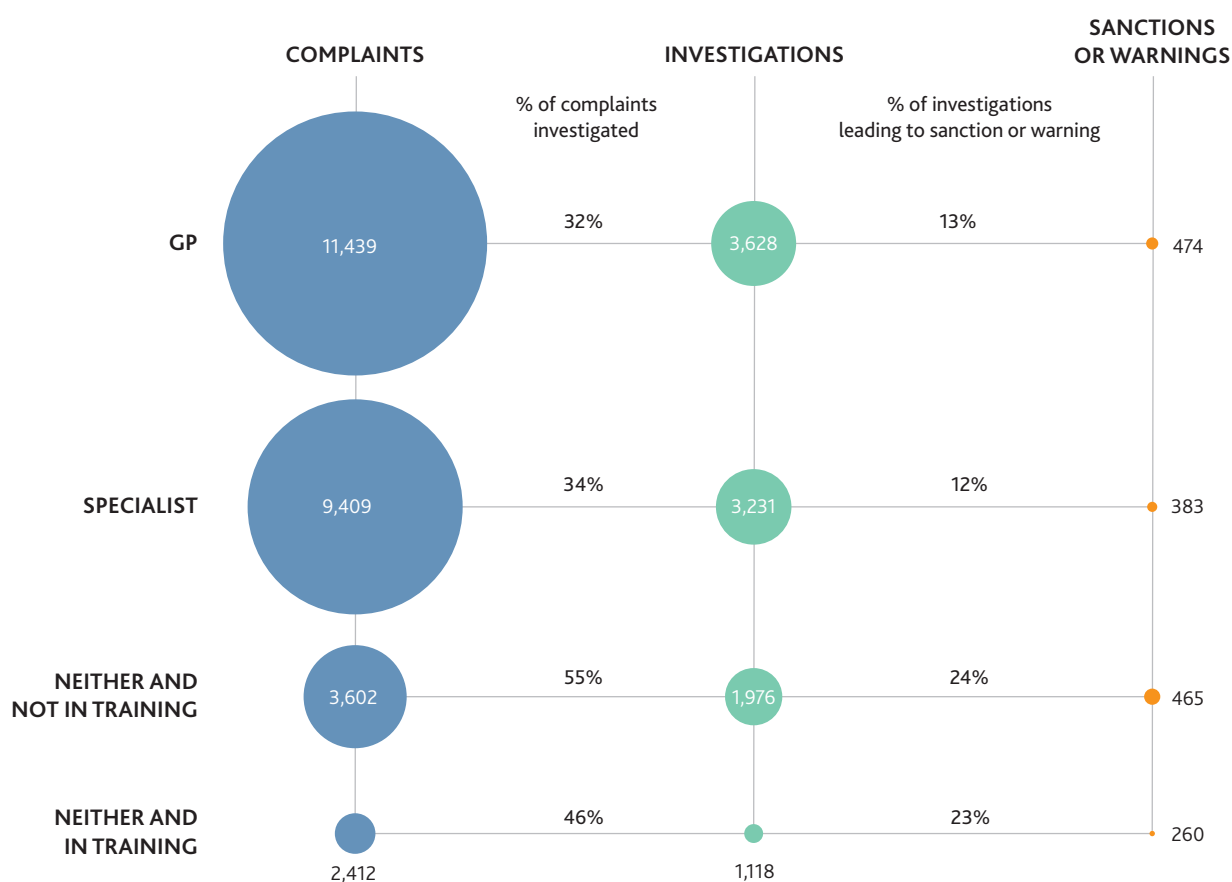
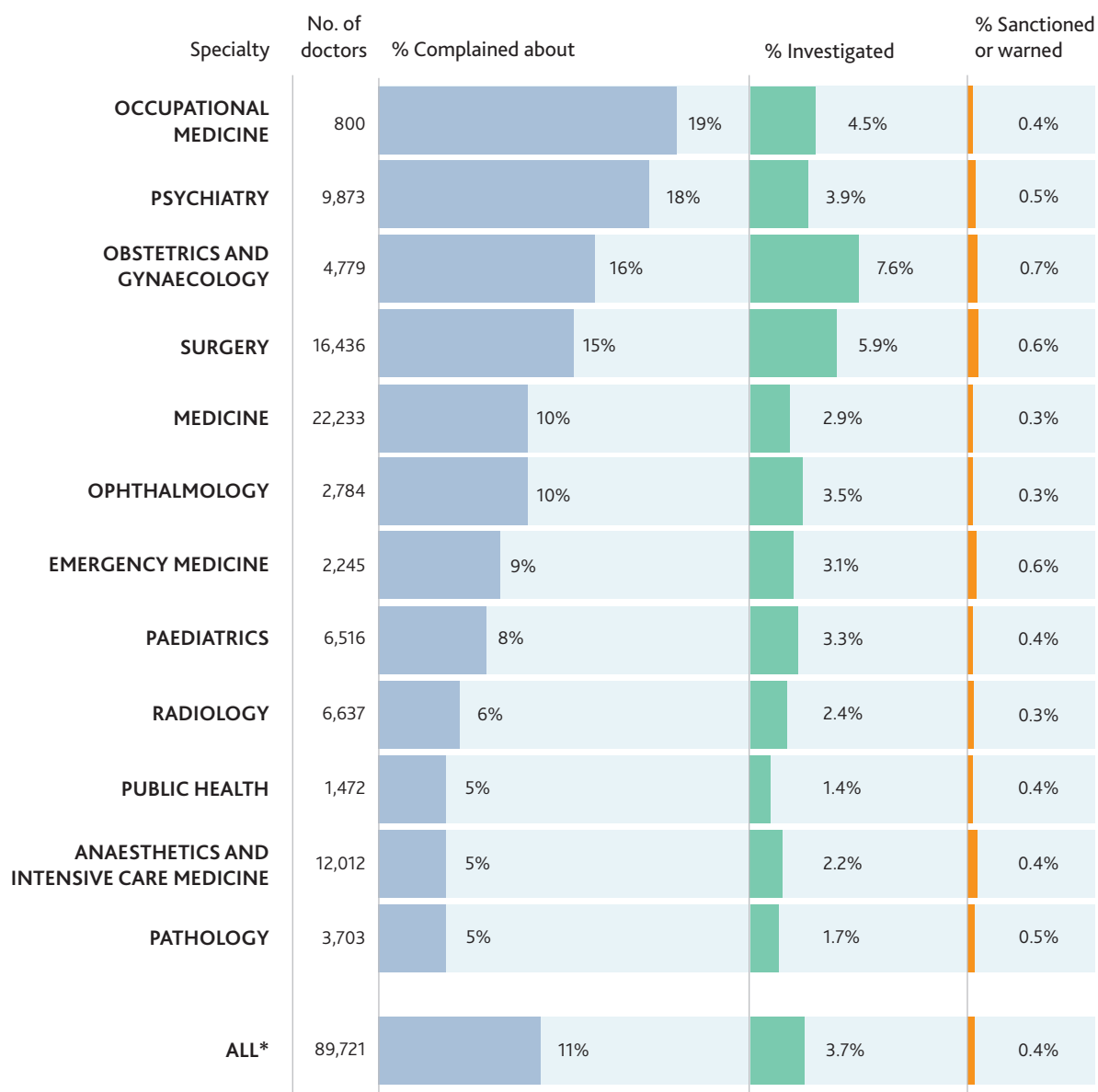


Figure 40: The proportion of specialists complained about, investigated, and sanctioned or warned, by specialty, from 2012 to 2016



* Total includes 231 doctors with multiple or other specialties.

Sources of complaints

The proportion of complaints leading to an investigation and to a sanction or a warning vary between the different sources of the complaint and between the different types of allegations contained in the complaint (see next section). In general between 2012 and 2016 complaints from the general public were far less likely to result in an investigation and in a sanction or a warning

(see figure 41). Only one in a 100 complaints from the public made between 2012 and 2016 have so far resulted in a sanction or a warning (a very small proportion are still in progress). In contrast the equivalent proportion for concerns raised by employers or the police was about one in four.

Figure 41: The proportion of complaints from each source leading to a sanction or a warning, from 2012 to 2016

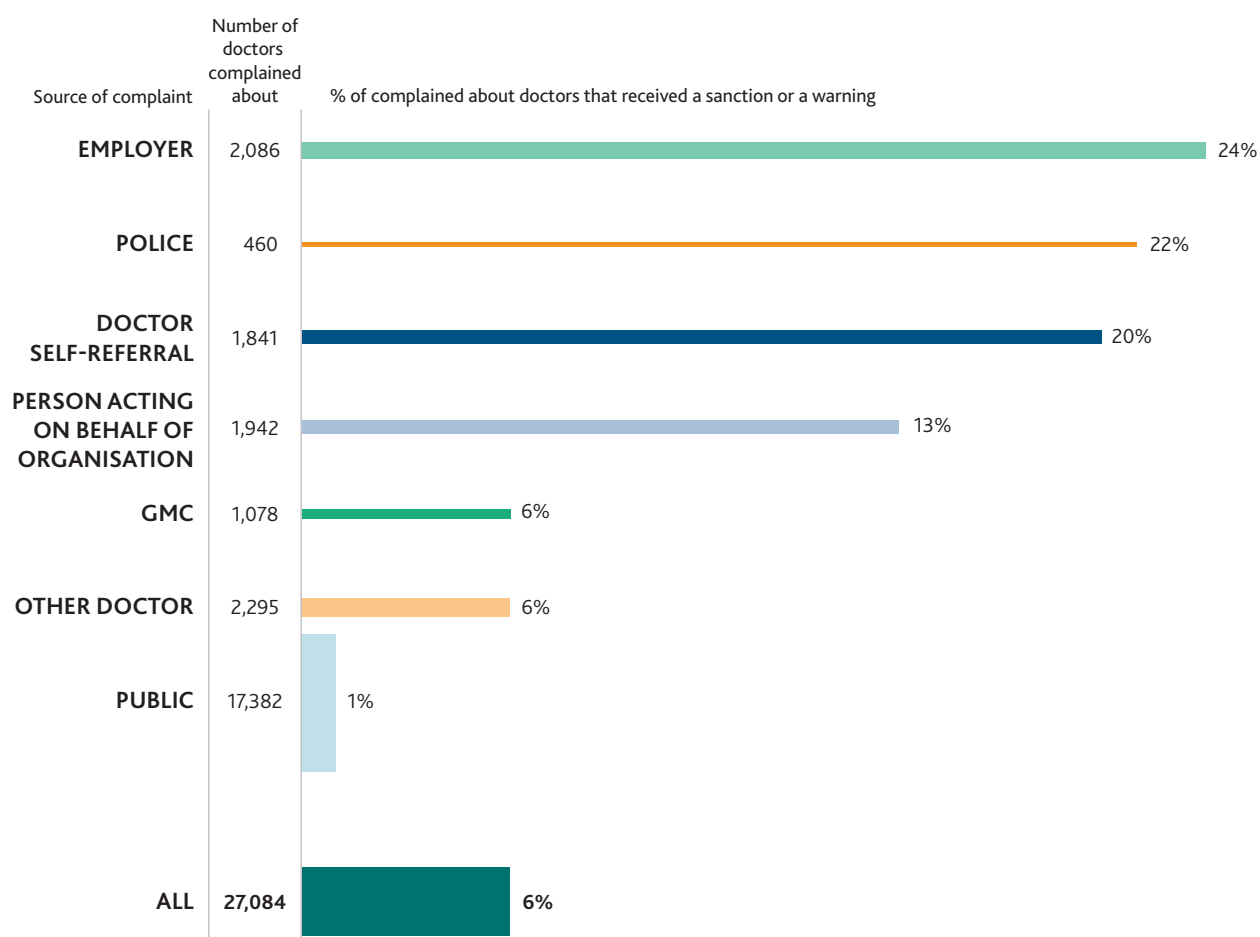
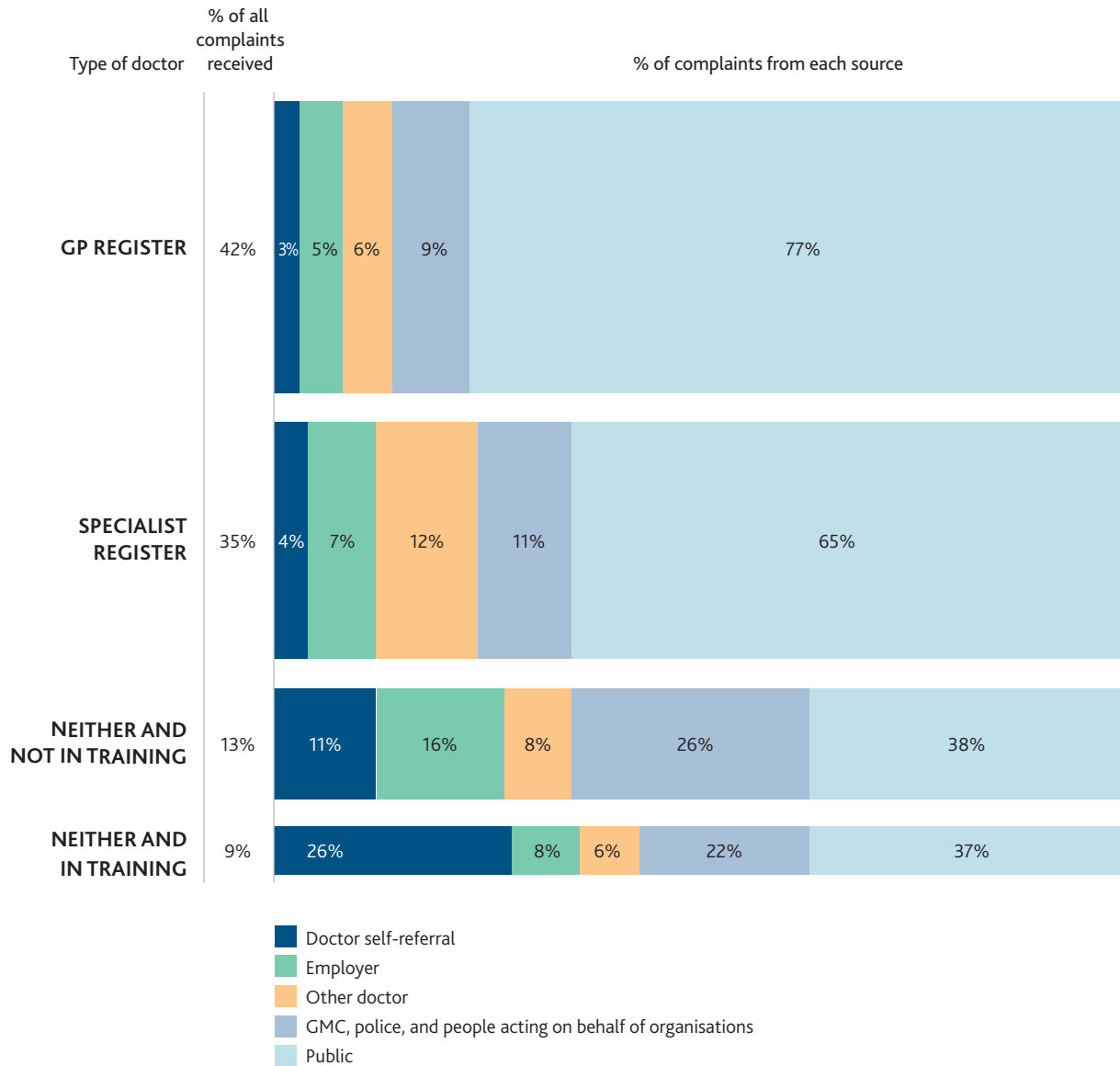


Figure 42: Source of complaints about different types of doctors, from 2012 to 2016



Box 7: Sources of complaints

We use the term 'complaints' to capture not only complaints from the public, who might be patients, or family or friends of patients, 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.

Box 8: Investigations

Being investigated can be very stressful for all concerned. Within the constraints of the law and without threatening public safety the GMC is endeavouring to reform the fitness to practise process to reduce the stress involved where possible and reduce the number of full investigations that lead to no sanction or warning (see box 4, page 83–84 for details of this reform programme).

This involves ensuring that wherever possible complaints and investigations are handled at local level, where learning can more easily take place. There are some early indicators of our Fitness to Practise reforms beginning to have an impact on the trends in complaints and investigations in recent years.

The types of allegations made against doctors

The possibility of an investigation resulting in a sanction or a warning not only varies by the source of the initial complaint but also varies depending on what the case is about. We have defined ten types of allegations (see box 5, chapter 3 on page 85) that have different rates of leading to a sanction or a warning as shown in figure 43, page 102.

Allegations about a doctor's health are most likely to lead to conditions or undertakings

In the period 2012 to 2016 the percentage of full investigations resulting in a sanction or a warning was highest for allegations about a doctor's health (50%) and probity-criminality (31%). These two types of allegations accounted for one in five investigations.

Of the allegations about a doctor's health leading to sanction or warning, 81% were given conditions or undertakings.

Investigations about clinical competence only, or clinical competence and communication or respect issues, accounted for 27% of investigations, but fewer than 5% of these investigations led to a sanction or a warning.

Professional performance concerns made up nearly a quarter of all investigations and 12% of these led to a sanction or a warning.

Different sources of complaints are associated with different allegations

Health concerns are most often raised by employers or self-referrals. Between 2012 and 2016 nearly one in five (19%) of doctor self-referrals and nearly one in six (15%) of employer referrals related to health (see figure 44, page 103).

Over half of the allegations made by the police or self-referrals related to **probity** or **criminality** (53% and 52% respectively). In contrast only about one in 50 investigations stemming from public complaints related to these.

The public tend to complain more about **professional performance** and **clinical competence**. Between 2012 and 2016 over three quarters (77%) of investigations stemming from complaints from the public referred to a doctor's professional performance or clinical competence. These allegations accounted for about half (47%) of investigations from employer complaints and only about one in seven from complaints made by the police and or self-referrals (15% each).

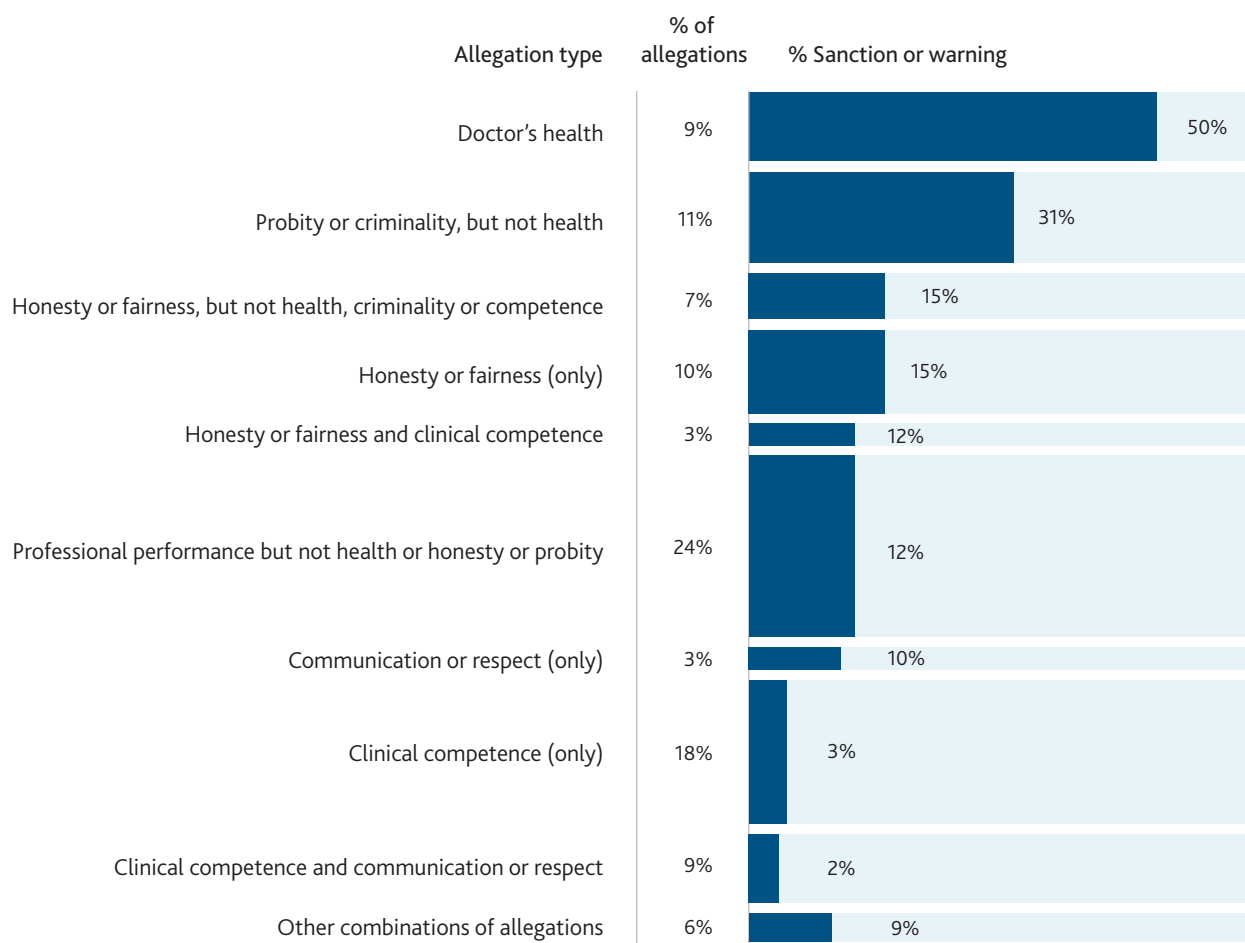
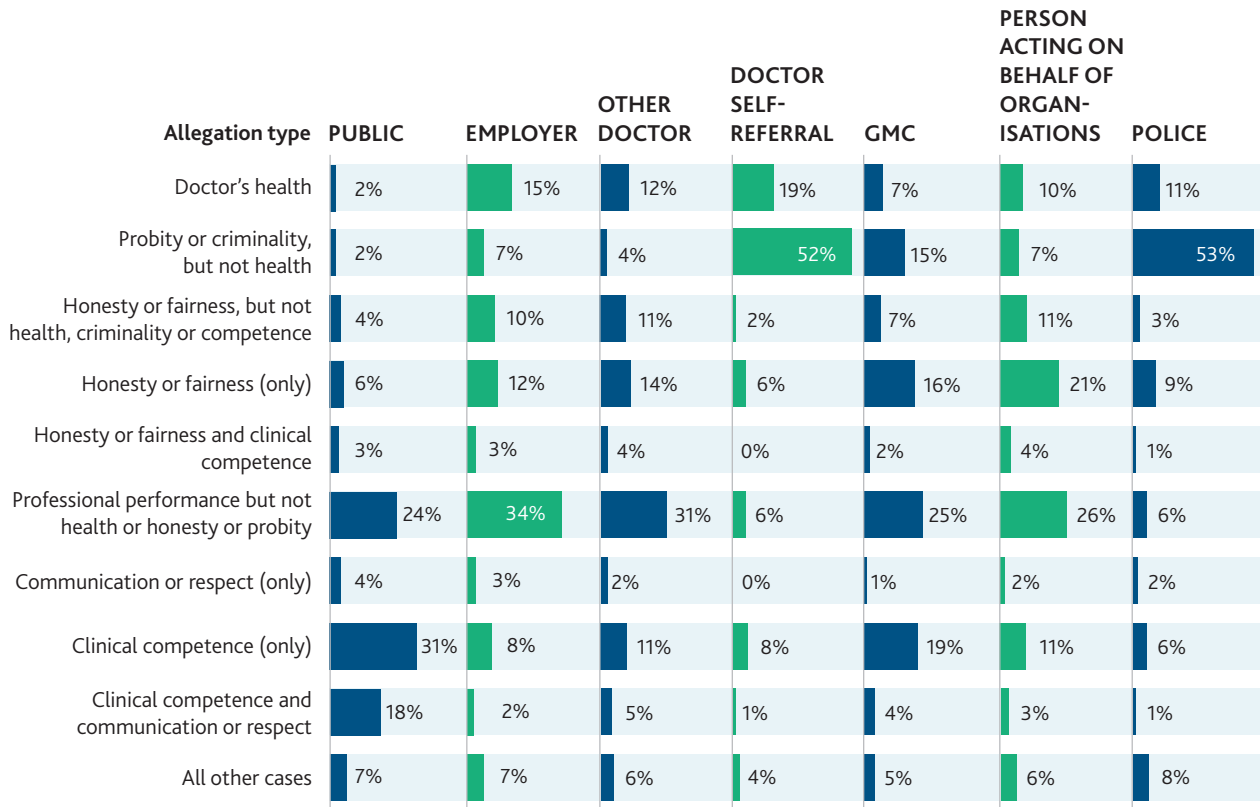
Figure 43: Proportion of investigations leading to a sanction or a warning, from 2012 to 2016

Figure 44: Types of allegations made between 2012 and 2016 by source of complaint*



* Individual sources sum to 100%.

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

A variety of complaints come into the GMC from different sources and relate to different allegations as shown above. The most likely source of a complaint and type of case vary across areas of practice and demographic groups and in relation to where doctors received their primary medical qualification. In this section we summarise in broad terms the rates of being complained about, having the complaint fully investigated, and receiving a sanction or a warning – in relation to ethnicity and place of primary medical qualification and in relation to age and gender. The differences highlighted here will partly relate to the fact that these groups have varying proportions of investigations coming from each source and being about each type of allegation.

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 in particular areas of practice, so the differences between groups would be masked if we looked at the data for all types of doctors together.

Overall, fewer than one in 100 doctors on the register received a sanction or a warning in the period 2012 to 2016. Even in groups with a higher rate of receiving a sanction or a warning from the GMC, the vast majority did not receive a sanction or a warning.

This means that even in groups of doctors with double the risk, the vast majority are not subject to sanctions or warnings. Although the numbers are small, we still need to understand where the risk of a sanction or a warning is heightened to investigate further the causes of this and determine whether there is an intervention that could reduce the risks to patient safety.

The 2016 data we have added this year have not changed the broad conclusions we reached previously.

Groups with a higher rate of being complained about include:

- IMG* GPs
- male doctors.

Groups with a higher rate of receiving a sanction or a warning include:

- GPs who graduated outside the UK (collectively EEA graduates† and IMGs)
- GPs with no recorded ethnicity
- male doctors.

But it is important to stress again, even in these groups, most doctors were not complained about and of those who were very few received a sanction or a warning in the period from 2012 to 2016.

* 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.

Male GPs have the highest rate of being complained about compared with female GPs and other register types

GPs have the highest rates of being complained about and having a complaint investigated, followed by specialists. Doctors on neither the GP nor the Specialist Register have a lower rate of being complained about, particularly those who are in training (see figure 45, page 106).

Nearly a quarter of male GPs were complained about, and the rate of being complained about was the same for male GPs aged over and under 50 years (22%). Female GPs had lower rates of being complained about when compared with their male colleagues.

The groups of doctors with the lowest rate of being complained about were female doctors under 50 years old who were on neither register. Only 3% of these groups were complained about between 2012 and 2016.

Males also have a higher rate of receiving a sanction or a warning

Male doctors under 50 years old on neither register and not in training had a sanction or a warning rate of 0.93%, whilst their female colleagues were half as likely to receive a sanction or a warning (0.42%).

Female specialists under 50 years old had a sanction or a warning rate of 0.2% and female doctors on neither register and in training aged under 50 years also had low rates of sanction or warning (0.28%).

Figure 45: Proportion of doctors who were complained about, had a complaint investigated, or received a sanction or a warning, by age and gender, from 2012 to 2016

TYPE OF DOCTOR	AGE	50 or more		Under 50		Total
	GENDER	Female	Male	Female	Male	
GP						
Number on the medical register		11,797	19,367	22,753	15,021	68,938
% of doctors complained about		13%	22%	11%	22%	17%
% of doctors with a complaint investigated		30%	36%	24%	33%	32%
% of investigations that led to a sanction or a warning		9%	14%	10%	14%	13%
% of complaints ending in a sanction or a warning		2.8%	5.1%	2.5%	4.7%	4.1%
% of doctors that received a sanction or a warning		0.36%	1.13%	0.26%	1.02%	0.69%
SPECIALIST						
Number on the medical register		10,197	29,464	18,788	29,694	88,143
% of doctors complained about		8%	14%	6%	11%	11%
% of doctors with a complaint investigated		29%	36%	27%	36%	34%
% of investigations that led to a sanction or a warning		8%	12%	11%	13%	12%
% of complaints ending in a sanction or a warning		2.3%	4.3%	3.1%	4.6%	4.1%
% of doctors that received a sanction or a warning		0.18%	0.60%	0.20%	0.51%	0.43%
NEITHER AND IN TRAINING						
Number on the medical register		131	120	34,994	26,264	61,509
% of doctors complained about		5%	13%	3%	5%	4%
% of doctors with a complaint investigated		33%	81%	40%	51%	46%
% of investigations that led to a sanction or a warning		50%	31%	24%	23%	23%
% of complaints ending in a sanction or a warning		16.7%	25.0%	9.5%	11.6%	10.8%
% of doctors that received a sanction or a warning		0.76%	3.33%	0.28%	0.59%	0.42%
NEITHER AND NOT IN TRAINING						
Number on the medical register		5,324	11,281	22,164	26,003	64,772
% of doctors complained about		5%	9%	3%	6%	6%
% of doctors with a complaint investigated		49%	54%	48%	59%	55%
% of investigations that led to a sanction or a warning		14%	21%	26%	26%	24%
% of complaints ending in a sanction or a warning		6.9%	11.2%	12.5%	15.1%	12.9%
% of doctors that received a sanction or a warning		0.34%	0.98%	0.42%	0.93%	0.72%

Place of primary medical education and ethnic groups

Most licensed doctors who were registered to work in the UK between 2012 and 2016 and whose ethnicity we know (see box 9) fell into one of four groups: white UK graduates (41%), IMGs who are BME (18%), UK graduates who are BME (12%), and white EEA graduates (9%).

There are then two much smaller groups: white IMGs (3%) and EEA graduates (excluding the UK) who are BME (1%). The remaining doctors (16%) have not declared their ethnicity to us. This year, for the first time, we have included these doctors with unknown ethnicity separately in the analysis.

GPs who graduate outside the UK are generally more likely to receive a sanction or a warning compared with those who graduate in the UK

Between 2012 and 2016 the rate of a doctor being complained about, having a complaint investigated, and receiving a sanction or a warning varied by PMQ and ethnicity and also by register type (see figure 46, pages 108–109).

In terms of the groups of doctors with the highest and lowest rates of complaints:

- Just under a quarter (23%) of IMG BME GPs were complained about compared with 17% of their UK BME counterparts.
- BME and white UK graduates and white EEA graduates who are on neither register and in training had the lowest rate of being complained about (4%) across all the groups.

Box 9: Doctors with no recorded ethnicity

The GMC aims to capture ethnicity data on all doctors. However, 16% of doctors (from 2012 to 2016) chose not to report their ethnicity. In previous editions of this report we excluded doctors who did not report their ethnicity from selected parts of the analysis.

It is important to include these data as IMG GPs with no recorded ethnicity have the highest complained about rate (alongside BME IMG GPs) and IMG and EEA graduate GPs who don't disclose their ethnicity have relatively high sanction or warning rates compared with most other PMQ-ethnicity groups, though the overall numbers in these groups are low.

In terms of the rates of sanctions and warnings, overall differences were relatively low between groups of doctors and numbers are low. Care must be taken in drawing too firm conclusions from these data:

- 1.77% of BME EEA doctors on neither the GP nor the Specialist Register and not in training had a sanction or warning and EEA GPs with no recorded ethnicity had a sanction or a warning rate of 1.49%
- BME UK doctors on neither register and not in training also had a relatively high sanction and warning rate (0.93%) as did IMG GPs with no recorded ethnicity (1.36%).
- BME UK specialists do not have a high rate of sanctions or warnings compared to white UK specialists (0.32% and 0.31% respectively).
- Doctors on neither register and in training had sanction and warning rates of 0.18% for EEA white doctors and 0.29% for white UK doctors.

We are investigating the extent to which different rates of sanction or warning are linked to whether doctors attend or have legal representation in

their hearing and plan to publish our findings in early 2018.

Figure 46: Proportion of doctors who were complained about, had a complaint investigated, or received a sanction or a warning, by PMQ and ethnicity, from 2012 to 2016

PLACE OF PMQ		EEA			IMG			UK			Total
TYPE OF DOCTOR	ETHNICITY	BME	Not recorded	White	BME	Not recorded	White	BME	Not recorded	White	
GP											
Number on the medical register		418	1,004	2,741	8,134	2,646	874	7,029	11,363	34,729	68,938
% of doctors complained about		22%	19%	16%	23%	23%	22%	17%	18%	14%	17%
% of doctors with a complaint investigated		37%	41%	37%	39%	41%	37%	33%	33%	26%	32%
% of investigations that led to a sanction or a warning		21%	19%	17%	13%	14%	13%	12%	16%	11%	13%
% of complaints ending in a sanction or a warning		7.6%	7.8%	6.3%	4.9%	5.9%	4.7%	3.9%	5.3%	2.8%	4.1%
% of doctors that received a sanction or a warning		1.67%	1.49%	0.99%	1.16%	1.36%	1.03%	0.64%	0.93%	0.39%	0.69%
SPECIALIST											
Number on the medical register		844	2,759	12,222	15,769	2,951	2,865	6,904	7,244	36,585	88,143
% of doctors complained about		11%	6%	6%	13%	8%	12%	12%	10%	12%	11%
% of doctors with a complaint investigated		47%	52%	43%	41%	45%	37%	33%	33%	28%	34%
% of investigations that led to a sanction or a warning		19%	24%	22%	12%	8%	12%	8%	9%	9%	12%
% of complaints ending in a sanction or a warning		8.7%	12.3%	9.3%	5.1%	3.8%	4.5%	2.7%	3.0%	2.6%	4.1%
% of doctors that received a sanction or a warning		0.95%	0.69%	0.61%	0.63%	0.30%	0.56%	0.32%	0.29%	0.31%	0.43%
NEITHER AND IN TRAINING											
Number on the medical register		450	176	1,673	4,959	1,347	458	14,954	3,793	33,699	61,509
% of doctors complained about		6%	7%	4%	8%	7%	7%	4%	4%	3%	4%
% of doctors with a complaint investigated		59%	83%	54%	57%	58%	48%	44%	45%	41%	46%
% of investigations that led to a sanction or a warning		31%	20%	8%	24%	27%	19%	24%	23%	23%	23%
% of complaints ending in a sanction or a warning		18.5%	16.7%	4.3%	13.6%	15.5%	9.1%	10.8%	10.4%	9.6%	10.8%
% of doctors that received a sanction or a warning		1.11%	1.14%	0.18%	1.05%	1.11%	0.66%	0.43%	0.45%	0.29%	0.42%

TYPE OF DOCTOR	PLACE OF PMQ	EEA			IMG			UK			Total
	ETHNICITY	BME	Not recorded	White	BME	Not recorded	White	BME	Not recorded	White	
NEITHER AND NOT IN TRAINING											
Number on the medical register		1,298	1,578	8,550	21,397	7,871	3,633	4,527	3,890	12,028	64,772
% of doctors complained about		7%	5%	3%	6%	5%	5%	6%	6%	5%	6%
% of doctors with a complaint investigated		68%	59%	57%	59%	64%	56%	53%	50%	40%	55%
% of investigations that led to a sanction or a warning		37%	14%	22%	23%	25%	23%	27%	22%	22%	24%
% of complaints ending in a sanction or a warning		24.7%	8.2%	12.7%	13.3%	16.2%	12.7%	14.4%	11.2%	8.9%	12.9%
% of doctors that received a sanction or a warning		1.77%	0.44%	0.39%	0.85%	0.86%	0.69%	0.93%	0.72%	0.47%	0.72%

In the largest specialties male doctors and non-UK graduates were more likely to receive a sanction or a warning

For most individual specialties samples are very small, but figure 47 on page 110 provides data for the four largest ones (medicine, surgery, anaesthetics and intensive care medicine, and psychiatry). In all of these, between 2012 and 2016, female doctors were less likely to receive a sanction or a warning than male doctors and UK graduates were less likely to receive these than those who graduated abroad.

EEA graduates who work in surgery and medicine are less complained about and investigated than UK or IMG graduates

Between 2012 and 2016 over a quarter of doctors on the Specialist Register who were EEA graduates specialised in surgery, compared with 17% of UK graduates and 15% of international

graduates. EEA surgeons were less complained about and less investigated than surgeons with a UK or IMG qualification.

Slightly under a fifth (22% of EEA graduates and 21% of IMGs) of doctors on the Specialist Register who graduated outside the UK and slightly over a fifth (27%) who were UK graduates specialised in medicine. The EEA graduate specialists in medicine were also less complained about and less investigated when compared with UK and IMGs in this specialty group.

Approximately a quarter of both male and female doctors on the Specialist Register worked in medicine; within this group male doctors were more complained about, had their complaint investigated and received a sanction or a warning than female doctors.

IMG doctors are more likely to be psychiatrists, but UK psychiatrists are most complained about

However, UK graduates in this specialty group were most complained about, whilst EEA doctors were most investigated and sanctioned or warned.

Between 2012 and 2016 IMG doctors were more likely to specialise in psychiatry (15%) when compared with UK (10%) and EEA (8%) graduates.

Figure 47: Rates of being complained about, having a complaint investigated, or being given a sanction or a warning for the four largest specialty groups, by gender and PMQ, from 2012 to 2016

SPECIALTY TYPE	Female	Male	EEA	IMG	UK
Medicine					
Number of Specialists	7,561	14,672	3,576	4,656	14,001
% Complained about	6%	12%	6%	11%	11%
% Investigated	1.5%	3.7%	2.2%	3.9%	2.8%
% Sanctioned or warned	0.15%	0.37%	0.50%	0.39%	0.21%
Surgery					
Number of Specialists	1,851	14,585	4,317	3,218	8,901
% Complained about	7%	16%	8%	18%	18%
% Investigated	2.4%	6.4%	3.9%	8.0%	6.2%
% Sanctioned or warned	0.11%	0.71%	0.81%	0.81%	0.51%
Anaesthetics and intensive care medicine					
Number of Specialists	3,940	8,072	2,052	2,758	7,202
% Complained about	3%	6%	4%	5%	5%
% Investigated	1.3%	2.6%	2.5%	2.8%	1.8%
% Sanctioned or warned	0.23%	0.50%	0.68%	0.65%	0.24%
Psychiatry					
Number of Specialists	4,071	5,802	1,335	3,195	5,343
% Complained about	13%	21%	14%	17%	19%
% Investigated	2.3%	5.1%	4.6%	4.0%	3.7%
% Sanctioned or warned	0.22%	0.71%	0.97%	0.53%	0.37%



5 Regional and country differences in our data about doctors

Summary

In this chapter we look at variations in how the medical workforce is deployed and distributed across the UK. In this year's report, for the first time, we are able to present country and regional data showing changes from 2012 to 2017.

The analysis here includes the number of doctors per person for different types of doctors. We also examine the diversity of the medical profession across the UK, and the age profile of different types of doctors.

Overall, most differences reported between the countries of the UK are relatively small, showing that there are far more similarities between the four countries than there are differences in terms of the overall number of licensed doctors and the demographics of the workforce. There are, however, some notable ways in which the countries and regions vary.

Scotland

There were 19,992 licensed doctors in Scotland in 2017. There are more GPs per head of population in Scotland, and fewer doctors who are neither GPs nor specialists per head of population.

Just over half of licensed doctors in Scotland are female (52%), compared with 47% across the whole UK.

Scotland has a higher reliance on UK-trained doctors than the UK average, with a lower proportion of non-UK graduates (17%). Given many IMGs are also BME, the lower proportion of BME doctors in Scotland (19%) is partly explained by this.

Wales

There were 9,989 licensed doctors in Wales in 2017. Wales continues to have slightly fewer GPs per head of population than other UK countries, and a slightly lower number of doctors in training.

A higher proportion of licensed doctors located in Wales are aged 50 years and over, 31.6% compared with a UK average of 29%. Between 2012 and 2017, the number of doctors in Wales aged under 50 years increased less than the UK average (0.4% increase, compared with a UK average increase of 8.7% for located doctors) while the number aged 50 years and over increased by 5.0% in line with the UK average.

Northern Ireland

There were 6,142 licensed doctors in Northern Ireland, which represents slightly more doctors per head of the population than the rest of the UK.

Half of licensed doctors in Northern Ireland are female, which is closer to the proportion of females in the wider population than the UK average of 47%.

Northern Ireland has a relatively high reliance on UK graduate doctors. Of the four UK countries it has the smallest proportion of

licensed doctors with a non-UK PMQ (14%). Linked to this, it also has the lowest proportion of BME doctors at 9%, which is still a relatively high rate of BME compared with the population of Northern Ireland.

The reliance on UK graduates has been increasing, with the number of licensed non-UK graduates reported in Northern Ireland down 13.8% from 2012 to 2017 (22% reduction in IMGs, 8% reduction in EEA graduates), while UK graduates increased by 8.2%. In Northern Ireland 386 out of 535 (72%) EEA graduates in 2017 qualified in the Republic of Ireland, making its EEA cohort unique in that it is mostly composed of one nationality. We provide further analysis of the EEA workforce in Northern Ireland and the UK in our publication *Our data about doctors with a European primary medical qualification in 2017*.²⁵

England

England contains 17 out of every 20 licensed doctors in the UK (84%). For this reason there is not much difference between what is reported here for England and the UK average. The differences between England and the other UK countries are simply the inverse of what we have reported for Scotland, Wales and Northern Ireland above.

There were, however, some notable differences when we examine and compare the regions of England.

- **London** has the highest number of specialists per head of population of any area, with over half again more specialists per head of population than the UK average. This is possibly due to a concentration of specialist hospitals and clinics in the capital.
- The **West Midlands** and **East Midlands** have the lowest proportion of female doctors (42% and 44% respectively), though this is fairly close to the UK average of 47%.
- The **West Midlands** is the only region of England with over half of its doctors with a known ethnicity reporting that they are BME.
- The **South West** has the highest number of GPs per head of population of any English region. But it should be noted that it also has a population that is older than most of the UK, which may increase the need for GP services. The South West also has a lower proportion of non-UK graduate doctors than the rest of England (18% compared with 34% in England overall). This partly explains the lower proportion of doctors who identify as BME (18% compared with 41% across England).

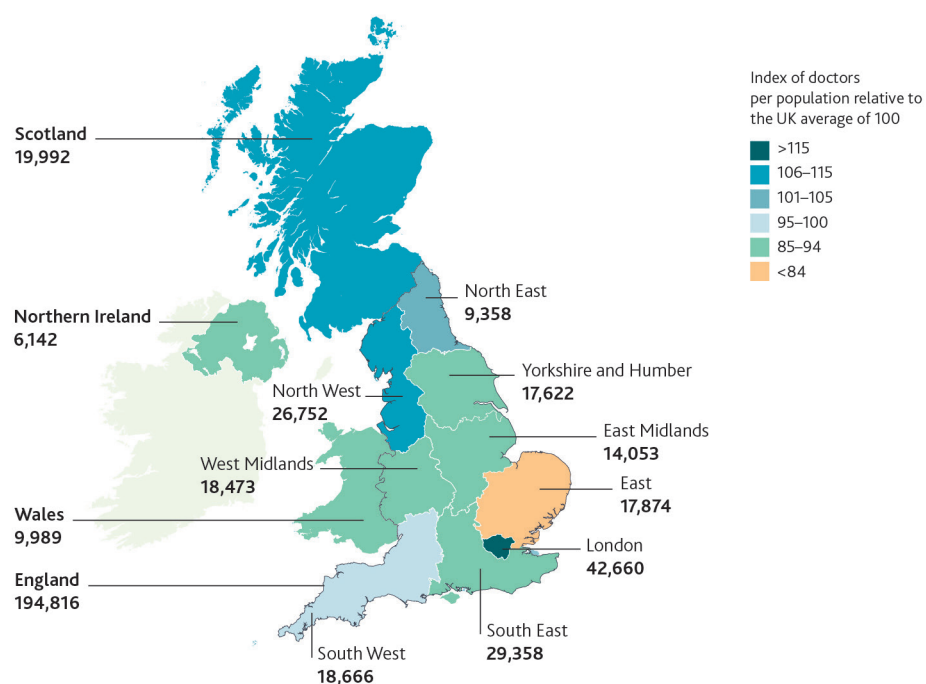
How many doctors are there across the UK?

Box 10: Data for doctors across different parts of the UK

We have been able to allocate 98% of licensed doctors on the medical register in 2017 into one of the four countries of the UK or to a region of England, see figure 44. The numbers on the register are taken as of 30 June on each year – previous reports used 31 December. Because of this, and some other improvements in our location method, data are not directly comparable with previous publications.

For doctors in training we used the address of their workplace given in the GMC's national training survey. For doctors working in the NHS we use their workplace address where available; data were not available for Northern Irish NHS workplace addresses. For other doctors we use 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 we have used the correspondence address held for the doctor.

Figure 48: Number of licensed doctors relative to the population* in 2017



*Excludes 2% of licensed doctors with unknown location

* Excludes 2% of licensed doctors with unknown location.

Wales continues to have fewer GPs per head of population than the other UK countries

We have used the number of GPs per 1,000 population in each country and region to investigate the density of GPs across the UK (see figure 49, pages 116–117).

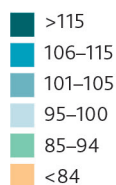
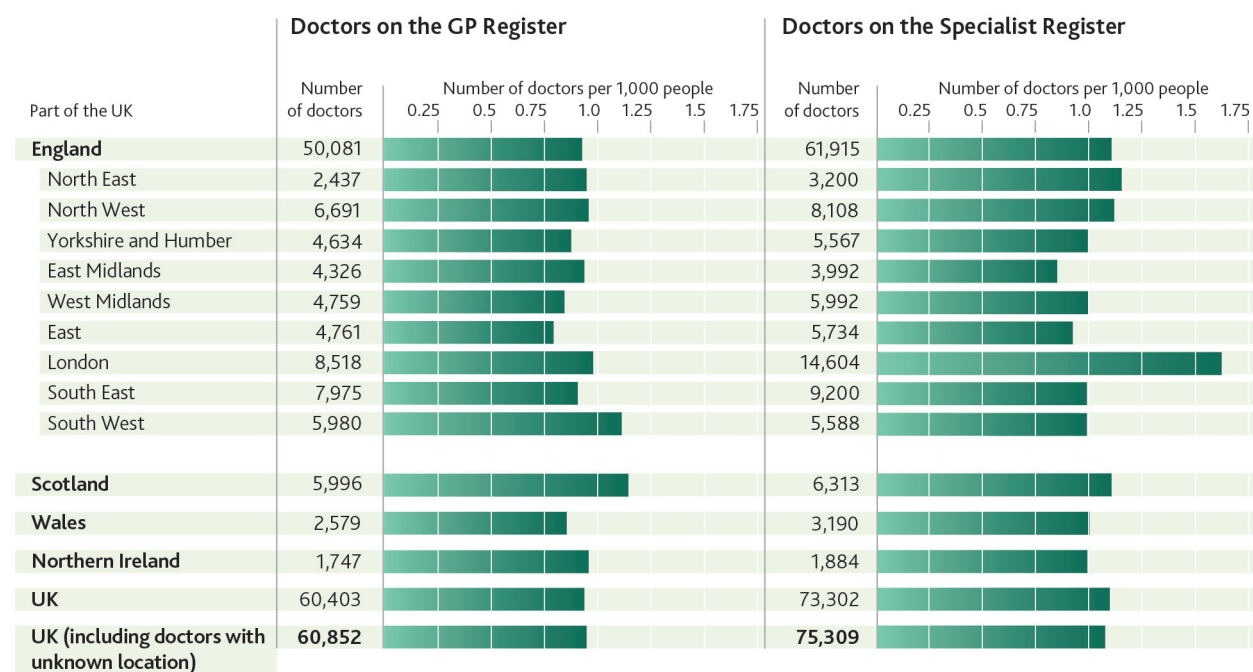
There are fewer GPs per head of population in Wales (0.83 per 1,000 people) compared with Scotland (1.11), England (0.90) and Northern Ireland (0.93).

Scotland and Northern Ireland have fewer doctors on neither register who are not in training (0.74 and 0.79 respectively) than other countries.

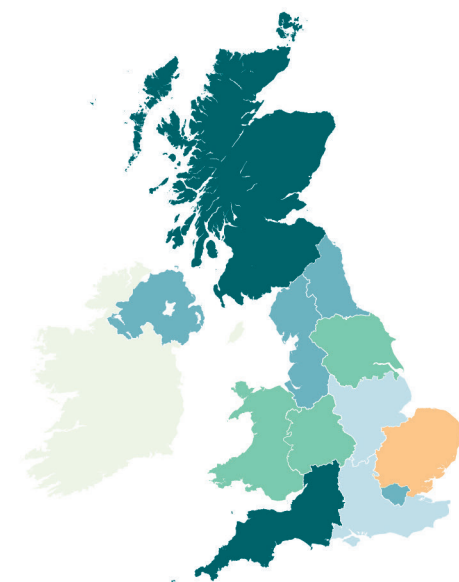
There are more specialists per head of population in London than any other area

With 1.63 specialists per 1,000 head of population, London has far more than the second densest region, the North East of England, which has 1.21. This probably reflects the concentration of specialists in areas like Harley Street and in the many teaching and specialist hospitals based in London. The East Midlands has the lowest density of specialists.

Figure 49: Number of different types of licensed doctors relative to the population by country and region in 2017



Index of the proportion of GPs per population relative to UK average of 100



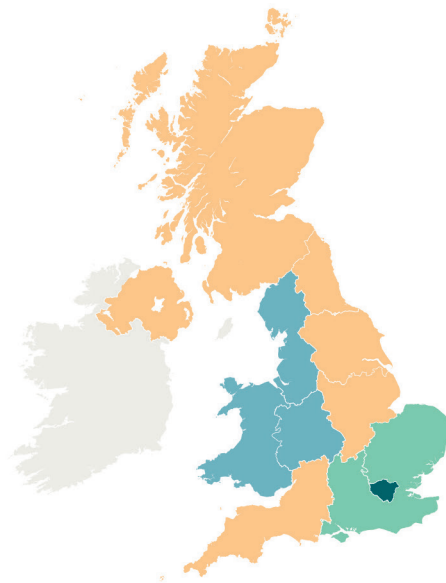
Index of the proportion of specialists per population relative to UK average of 100



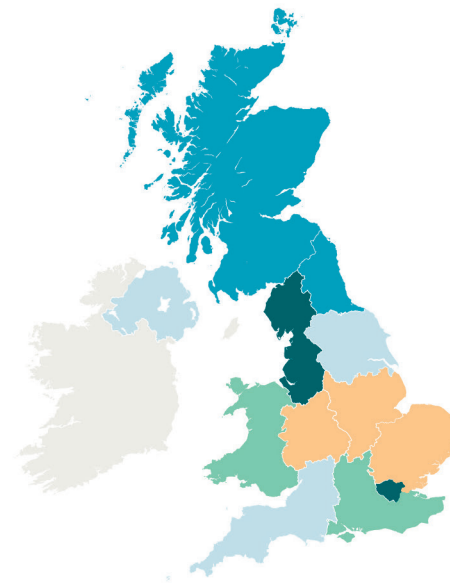
	Doctors not on the GP or Specialist Register								Doctors in training									
Part of the UK	Number of doctors	Number of doctors per 1,000 people								Number of doctors	Number of doctors per 1,000 people							
		0.25	0.5	0.75	1.0	1.25	1.5	1.75	0.25		0.5	0.75	1.0	1.25	1.5	1.75		
England	34,201								49,616									
North East	1,251								2,509									
North West	4,458								7,601									
Yorkshire and Humber	2,669								4,831									
East Midlands	2,310								3,490									
West Midlands	3,595								4,285									
East	3,474								4,015									
London	8,865								10,878									
South East	5,109								7,271									
South West	2,470								4,736									
Scotland	2,364								5,441									
Wales	1,888								2,385									
Northern Ireland	881								1,666									
UK	39,334								59,108									
UK (including doctors with unknown location)	42,631								59,194									



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



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



How diverse are doctors across the UK?

Wales and the English Midlands are the furthest from female-male parity, but are still close to the UK average

In Wales, 45% of doctors are female, compared with a UK average of 47% (see figure 50, page 119). However, from 2012 to 2017 the proportion of female doctors in Wales has increased by 10% - as shown in figure 54, page 124.

West and East Midlands have a lower proportion of female doctors than Wales, at 42% and 44% respectively – these regions of England show some of the smallest increases in the proportion of doctors who are female. We explore more deeply how the pattern is changing over time in each region and country on pages 123–125 and in figure 54, page 124.

Half or more of doctors in four areas are female

Half or just over half of licensed doctors are female in Scotland (52%), London (51%), South-west England (50%) and Northern Ireland (50%).

Northern Ireland has the fewest BME doctors

Nearly two fifths of licensed doctors in the UK identify as black and minority ethnic (BME). But the proportion is much lower in Scotland (19%), South-West England (18%) and Northern Ireland (9%).

The latter is linked to the fact that Northern Ireland is also 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, possibly in part due to its geographic separation from mainland UK.

The West Midlands stands out as the only region with over half of its licensed doctors identifying as BME (52% of doctors whose ethnicity is known).

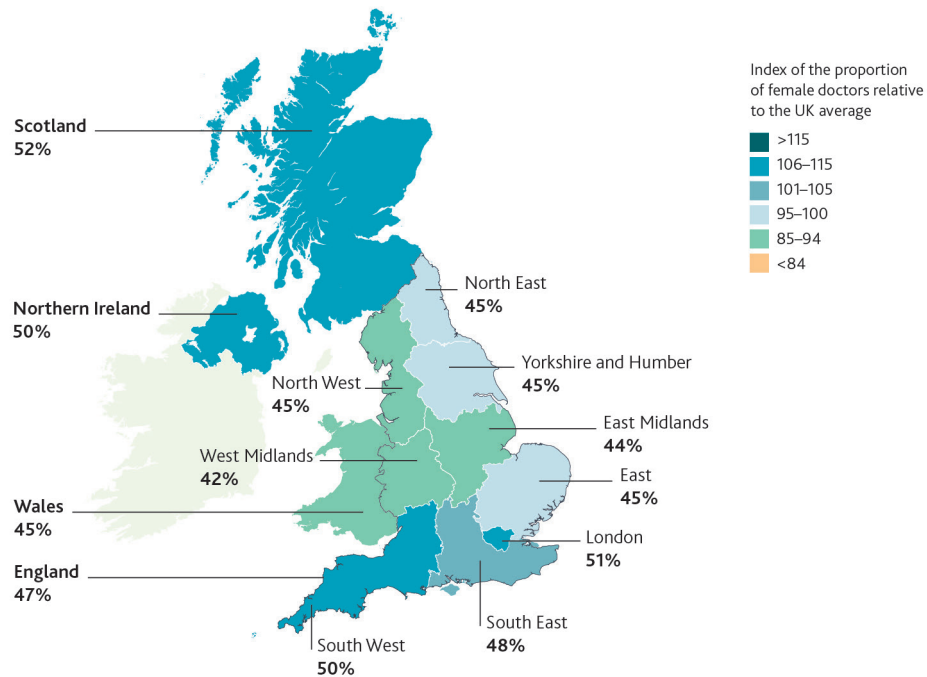
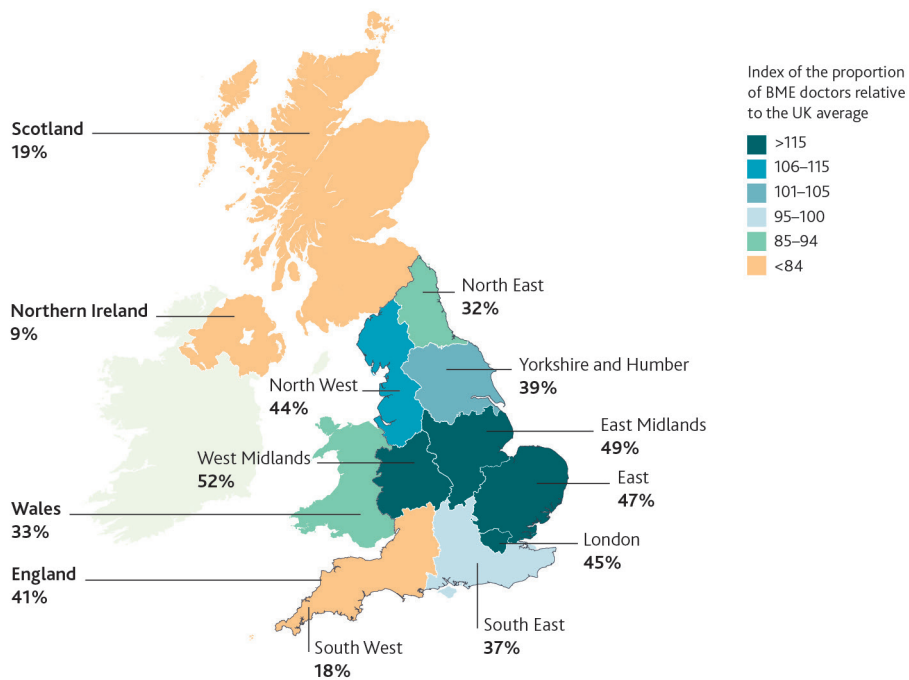
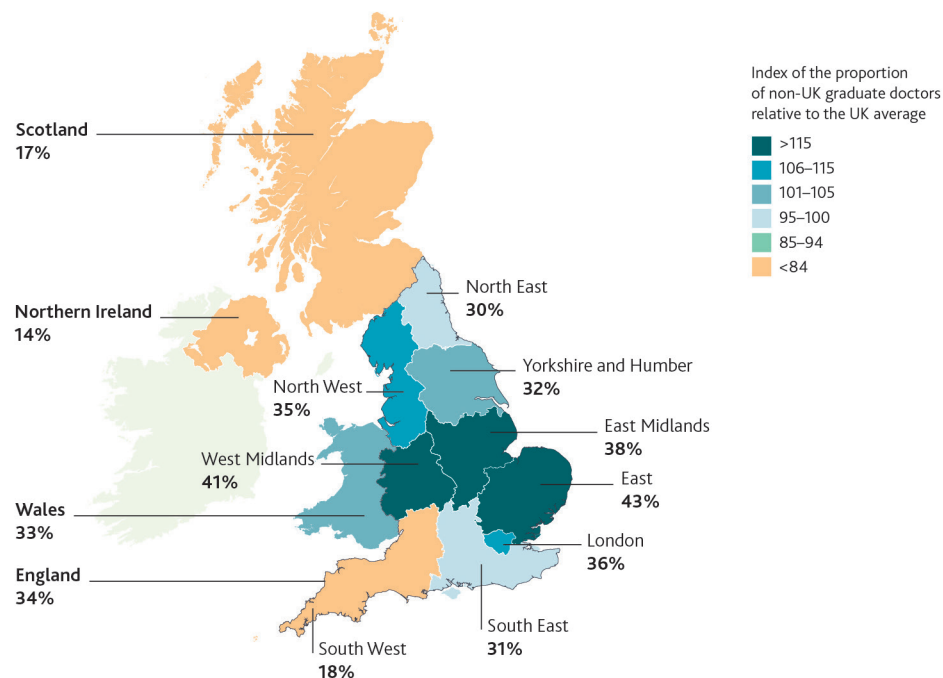
Figure 50: Proportion of licensed doctors who are female by country and region in 2017**Figure 51: Proportion of licensed doctors who are BME by country and region in 2017**

Figure 52: Proportion of licensed doctors who are non-UK graduates by country and region in 2017

Wales has a slightly higher proportion of older licensed doctors

In Wales, 31.6% of licensed doctors are aged 50 years and over, compared with the UK average of 28.3%. While this 3% difference is relatively small, it is worth noting as a consideration by those responsible for workforce planning.

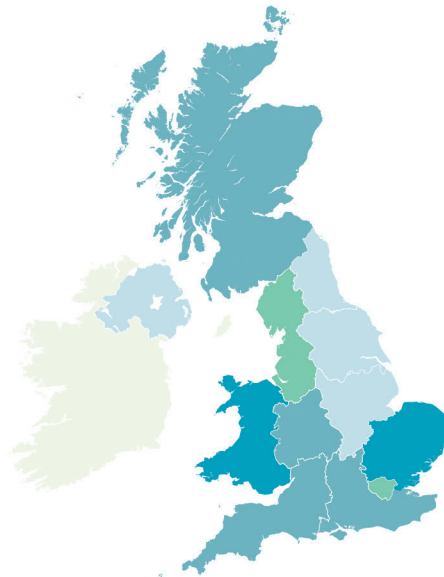
Wales also has the highest proportion of older doctors on both neither register and on the Specialist Register and has the second highest proportion of GPs aged 50 years and over out of the countries of the UK and regions of England (see figure 53, pages 121–122).

Figure 53: Age profile of doctors, by country and region and by type of registration in 2017

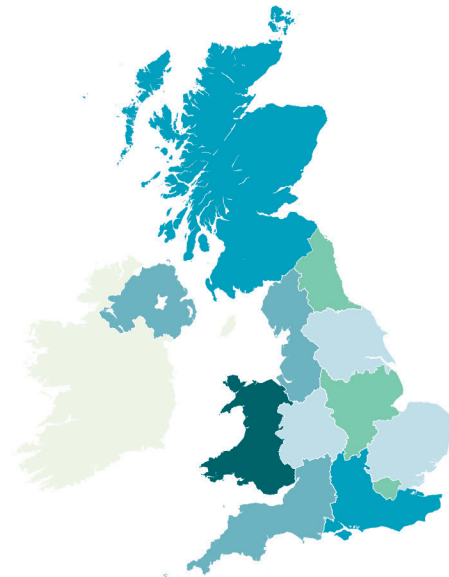
Part of the UK	All licensed doctors not in training					Licensed doctors on neither register and not in training				
	Number of doctors	Age (years)				Number of doctors	Age (years)			
		<40	40–49	50–59	≥60		<40	40–49	50–59	≥60
England	194,816	45%	27%	19%	9%	34,201	52%	25%	15%	8%
North East	9,358	44%	28%	20%	8%	1,251	55%	24%	14%	7%
North West	26,752	47%	27%	18%	8%	4,458	50%	27%	16%	7%
Yorkshire and Humber	17,622	45%	28%	20%	8%	2,669	52%	26%	15%	8%
East Midlands	14,053	43%	29%	20%	8%	2,310	52%	27%	14%	6%
West Midlands	18,473	42%	29%	20%	9%	3,595	49%	29%	16%	7%
East	17,874	41%	29%	21%	10%	3,474	50%	27%	16%	7%
London	42,660	48%	26%	16%	10%	8,865	56%	23%	12%	8%
South East	29,358	43%	28%	20%	9%	5,109	49%	26%	17%	8%
South West	18,666	43%	27%	22%	8%	2,470	53%	23%	16%	7%
Scotland	19,992	46%	26%	21%	7%	2,364	53%	23%	18%	6%
Wales	9,989	41%	27%	22%	10%	1,888	47%	26%	18%	9%
Northern Ireland	6,142	50%	23%	19%	8%	881	55%	22%	17%	6%
UK	230,939	45%	27%	20%	9%	39,334	52%	25%	15%	8%
UK (including doctors with unknown location)	236,732	45%	27%	20%	9%	42,631	53%	25%	15%	7%



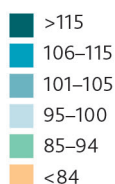
Index of the proportion of doctors aged 50 years and over relative to UK average of 100



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

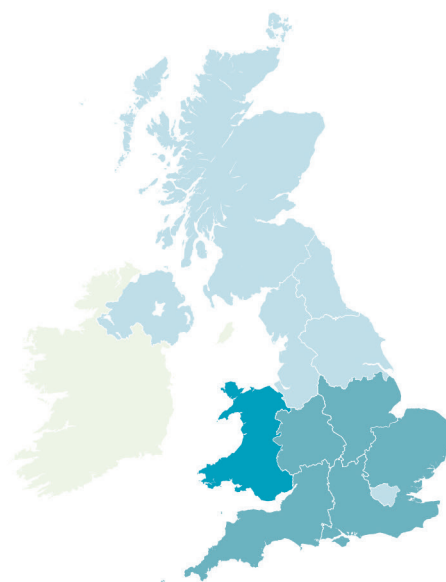


Part of the UK	Licensed doctors on the Specialist Register					Licensed doctors on the GP Register				
	Number of doctors	Age (years)				Number of doctors	Age (years)			
		<40	40–49	50–59	≥60		<40	40–49	50–59	≥60
England	61,915	14%	41%	31%	14%	50,081	29%	31%	27%	13%
North East	3,200	17%	40%	31%	12%	2,437	26%	34%	28%	12%
North West	8,108	15%	41%	30%	14%	6,691	32%	31%	26%	11%
Yorkshire and Humber	5,567	14%	42%	31%	13%	4,634	29%	32%	29%	10%
East Midlands	3,992	14%	41%	32%	13%	4,326	27%	33%	28%	12%
West Midlands	5,922	12%	42%	32%	13%	4,759	29%	30%	27%	13%
East	5,734	12%	42%	31%	15%	4,761	24%	31%	31%	14%
London	14,604	17%	40%	28%	15%	8,518	33%	28%	22%	17%
South East	9,200	13%	42%	31%	15%	7,975	26%	32%	30%	12%
South West	5,588	13%	42%	33%	12%	5,980	27%	32%	31%	11%
Scotland	6,313	16%	40%	32%	11%	5,996	28%	31%	31%	10%
Wales	3,190	11%	41%	34%	13%	2,579	26%	30%	30%	15%
Northern Ireland	1,884	18%	40%	29%	13%	1,747	34%	25%	29%	11%
UK	73,302	15%	41%	31%	14%	60,403	29%	31%	28%	13%
UK (including doctors with unknown location)	75,309	15%	41%	31%	14%	60,852	29%	31%	28%	13%

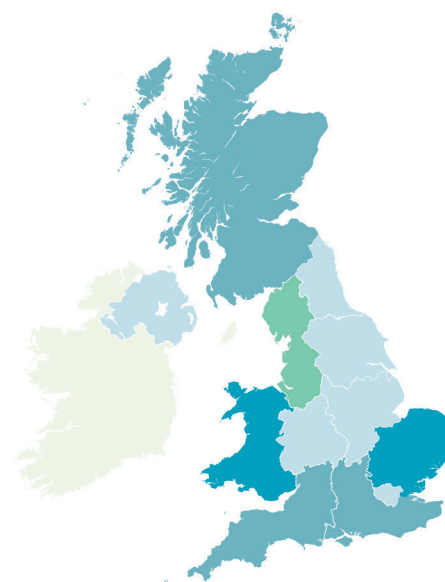


There are substantially more specialists per person in London than in any other country or region, potentially reflecting the concentration of specialists in areas like Harley Street and in the many teaching and specialist hospitals.

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



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



How have the characteristics of doctors changed over time in the countries of the UK?

Overall, there has been a 1.9% growth in licensed doctors between 2012 and 2017. Using our available data (see box 10 on page 114) we can identify which country a doctor is working in. Over time our data and ability to do this have improved – in 2012 we could not identify a UK location for 17,756 doctors (8%), and in 2017 this has improved to 5,793 doctors (2%). As a result of this, the increase over time reported for each country may reflect in part this improved ability to locate doctors (see box 11).

Each country of the UK reports different relative growth in the number of licensed doctors – England grew by 8%, Northern Ireland by 4%, Scotland by 4% and Wales by 2%.

Growth of younger doctors is high in England, and low in Wales

The 8% growth in the number of licensed doctors reported in England is driven more by doctors under 50 years old than by older ones. The number of those aged under 50 years increased by 9.8% (12,510 additional doctors), and those aged 50 years and over increased by only 5.1% (2,660 additional doctors).

The reverse of this is observed in Wales, where the growth was almost entirely seen in doctors aged 50 years and over – which grew by 5% (149 additional doctors), while doctors aged under 50 years remained almost the same with 0.4% growth (28 additional doctors).

The relative increase in female doctors is highest in England

The number of licensed female doctors in England increased by 16.5% (to 91,100) between 2012 and 2016. The number of male doctors in England increased by only 2.3% in the same period.

The growth in the number of female doctors was lower in Scotland (11.4%), Wales (10.0%) and Northern Ireland (11.2%). The differences are relatively small between each UK country and all have much higher growth in the number of female doctors than male doctors (see figure 54, pages 124–125).

Box 11: A note on data about doctors' locations

While there have been notable changes to the characteristics of doctors over time in the countries of the UK it is important to note that the introduction of revalidation in 2012 has meant that we have more accurate information in subsequent years on doctors characteristics. This information does not necessarily reflect changes to movement of doctors from country to country.

Figure 54: The changing make-up of licensed doctors by countries of the UK, between 2012 to 2017*

ENGLAND				SCOTLAND			
	2012	% change	2017		2012	% change	2017
Gender				Gender			
Male	101,426	2.3%	103,726	Male	9,900	-2.2%	9,684
Female	78,220	16.5%	91,100	Female	9,256	11.4%	10,308
Age				Age			
<50	127,541	9.8%	140,051	<50	13,684	4.3%	14,279
≥50	52,105	5.1%	54,765	≥50	5,472	4.4%	5,713
PMQ				PMQ			
UK	117,740	9.2%	128,580	UK	15,766	5.3%	16,597
Non-UK	61,906	7.0%	66,236	Non-UK	3,390	0.1%	3,395
Ethnicity				Ethnicity			
BME	59,429	18.6%	70,473	BME	2,620	15.1%	3,015
White	92,723	8.7%	100,805	White	11,808	10.8%	13,089
Unknown	27,494	-14.4%	23,538	Unknown	4,728	-17.8%	3,888

* This graphic excludes doctors whose locations were unknown. The proportion doctors of unknown location decreased consistently between groups, reducing between 60% and 70%, except for doctors with an unknown ethnicity. This group declined by 84% due to an increasing number of primarily BME doctors disclosing their ethnicity to us.

WALES

	2012	% change	2017
Gender			
Male	5,766	-4.0%	5,537
Female	4,046	10.0%	4,452

Age			
<50	6,808	0.4%	6,836
≥50	3,004	5.0%	3,153

PMQ			
UK	6,421	4.2%	6,689
Non-UK	3,391	-2.7%	3,300

Ethnicity			
BME	2,453	11.0%	2,722
White	4,989	8.4%	5,407
Unknown	2,370	-21.5%	1,860

NORTHERN IRELAND

	2012	% change	2017
Gender			
Male	3,106	-1.6%	3,057
Female	2,774	11.2%	3,085

Age			
<50	4,272	4.4%	4,458
≥50	1,608	4.7%	1,684

PMQ			
UK	4,873	8.2%	5,274
Non-UK	1,007	-13.8%	868

Ethnicity			
BME	463	-6.7%	432
White	4,053	12.9%	4,577
Unknown	1,364	-16.9%	1,133

In which country or region are doctors most likely to be complained about, investigated, or given a sanction or a warning?

Data presented here are pooled over the period 2012 to 2016 in order to increase sample size. However, it should be noted that 663* doctors across the UK had complaints about them that were still under investigation at the time data were extracted on 31 May 2017.

As we noted in more detail in previous chapters there are differences in the proportion of doctors complained about, the proportion of those complaints that reach our threshold for a full GMC investigation and the proportion of those investigations that then lead to a sanction or a warning. The overall impact of these stages combined leads to the proportion of doctors who end up with a sanction or a warning.

Doctors in England were more complained about than in any other UK region

Relative to a UK average of 100, England had more doctors complained about per licensed doctor (103) than in any other UK region – Scotland (87), Wales (89) and Northern Ireland (75).

The rate of complaints leading to investigation were broadly similar between UK countries, but were slightly higher in Wales

The proportion of complaints that lead to an investigation were broadly similar across the

countries of the UK. Just over two fifths of complaints (41%) in Wales led to a doctor being investigated. In England 37% of complaints resulted in an investigation, 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 leading to a sanction or a warning being given to a doctor was close between the countries. Scotland and Wales, at 17%, were only slightly higher than England (16%) and Northern Ireland (15%).

Doctors in Wales and England were more likely to be fully investigated

The net effect of these differences is that over the five-year period from 2012 to 2016, England and Wales had proportionately more doctors investigated; 44 and 43 per 1,000 licensed doctors respectively compared with 33 in Scotland and 29 in Northern Ireland.

* This figure excludes doctors with an unknown location.

Figure 55: Complaints, investigations, and sanctions or warnings, by region, using pooled data* from 2012 to 2016

Country of the UK	Licensed doctors	Doctors complained about	Doctors investigated	Doctors given a sanction or a warning
England	190,501	22,997	8,421	1,314
Scotland	19,602	1,993	639	109
Wales	9,761	1,015	418	71
Northern Ireland	5,978	530	176	26
UK TOTAL	225,842	26,535	9,654	1,520
UK TOTAL (including doctors with unknown location)	232,192	27,084	10,027	1,596

Country of the UK	Complaints per 1,000 licensed doctors	GMC investigations per 1,000 licensed doctors	Sanctions or warnings per 1,000 licensed doctors
England	121	44	7
Scotland	102	33	6
Wales	104	43	7
Northern Ireland	89	29	4
UK TOTAL	117	43	7
UK TOTAL (including doctors with unknown location)	117	43	7

Country of the UK	Complaints as a proportion of licensed doctors	GMC investigations as a proportion of complaints	Sanction or warning given as a proportion of GMC investigations
England	12%	37%	16%
Scotland	10%	32%	17%
Wales	10%	41%	17%
Northern Ireland	9%	33%	15%
UK TOTAL	12%	36%	16%
UK TOTAL (including doctors with unknown location)	12%	37%	16%

* Data are pooled and each doctor is counted only once where that doctor was complained about, fully investigated, or received a sanction or a warning given in any year.

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.

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

Data for the analysis of the profession in 2017 refer to the medical register (known as the List of Registered Medical Practitioners), 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 of each year between 2012 and 2017. Where data are aggregated over 2012–17, the unique count of doctors across the snapshots of each years data are used. 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 2011–16 was for enquiries either received or closed between 1 January 2011 and 31 December 2016. The data were drawn from the GMC's database on 31 May 2017. 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. 45% of complaints that originated in 2016 and were investigated did not yet have an outcome (640 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 2016 came from the medical schools' annual reports to us.

The number of doctors in postgraduate training programmes is from data that HEE local teams in England and deaneries in Northern Ireland, Scotland and Wales provided in the 2017 national training survey – it was accurate on 21 March 2017.

The 2017 national training survey was open from 21 March to 10 May 2017. Doctors in training were asked about the post they were in on 21 March 2017. 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 – 164 doctors were in this group in 2017.

Data relating to the age of a doctor

There is a small group of doctors on the register with no date of birth recorded (1.6% in 2012 and 1.1% in 2017). 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 13% of licensed doctors on the register in 2017.

Regional and country data

The index of doctors per population given in chapter 5 figure 48 was derived using a denominator based on mid-2017 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, Gambia, 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, Kosovo, Macedonia, Moldova, Montenegro, Russia, Serbia and Ukraine.

Middle East: Bahrain, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian Territories, Qatar, 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: Antigua and Barbuda, Argentina, Barbados, Belize, Bolivia, Brazil, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Curacao, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Peru, Saba, 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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