Summary: *The state of medical education and practice in the UK: 2013*

General Medical Council

Regulating doctors
Ensuring good medical practice

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

We hope this report will encourage discussion and debate about some of the practical steps we and others could take in better supporting doctors and improving patient care.

This year we have focused on complaints to the GMC to see if we can understand more about them and whether they can help us identify areas of risk within medical practice.

But the report needs to be seen in the wider context – the overall standard of medical practice in the UK is good, and we need to learn from best practice as well as have a better understanding of what happens when things go wrong.

This executive summary provides an overview of the report's main findings and conclusions.

The changing shape of the profession and medical education (chapter 1)

Shape of the profession since 2007

The number of doctors on the register has increased substantially from 244,540 doctors in 2007 to 252,553 in 2012.

Overall, the most substantial change in this period has been the growth in the number of female doctors. But now this seems to be slowing: 55% of medical students were female in 2012, compared with 61% in 2003 and 57% in 2007.

27% of doctors on the register were international medical graduates in 2012, but the supply of these doctors is reducing and the group is ageing. The number of international medical graduates under 30 years old decreased by 61% between 2007 and 2012. Graduates from the UK and European Economic Area (EEA) are now filling this gap as fewer international medical graduates are able to start postgraduate training in the UK.

Where doctors are working

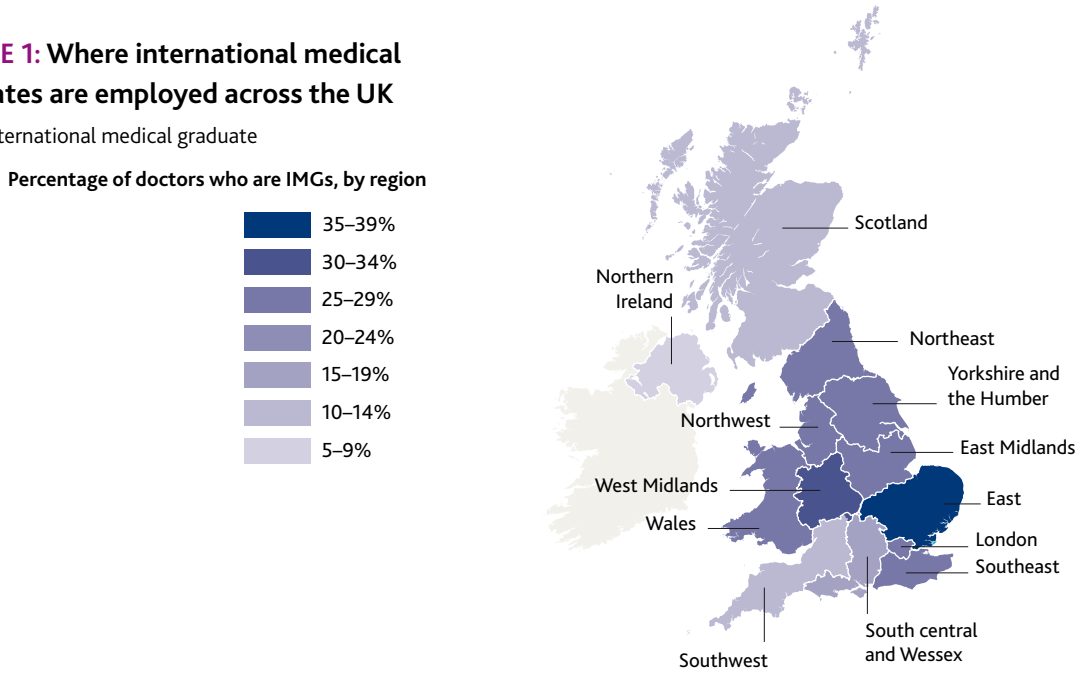
London and Scotland have the highest numbers of doctors per 100,000 people, and the East Midlands, east and southeast of England have the lowest.

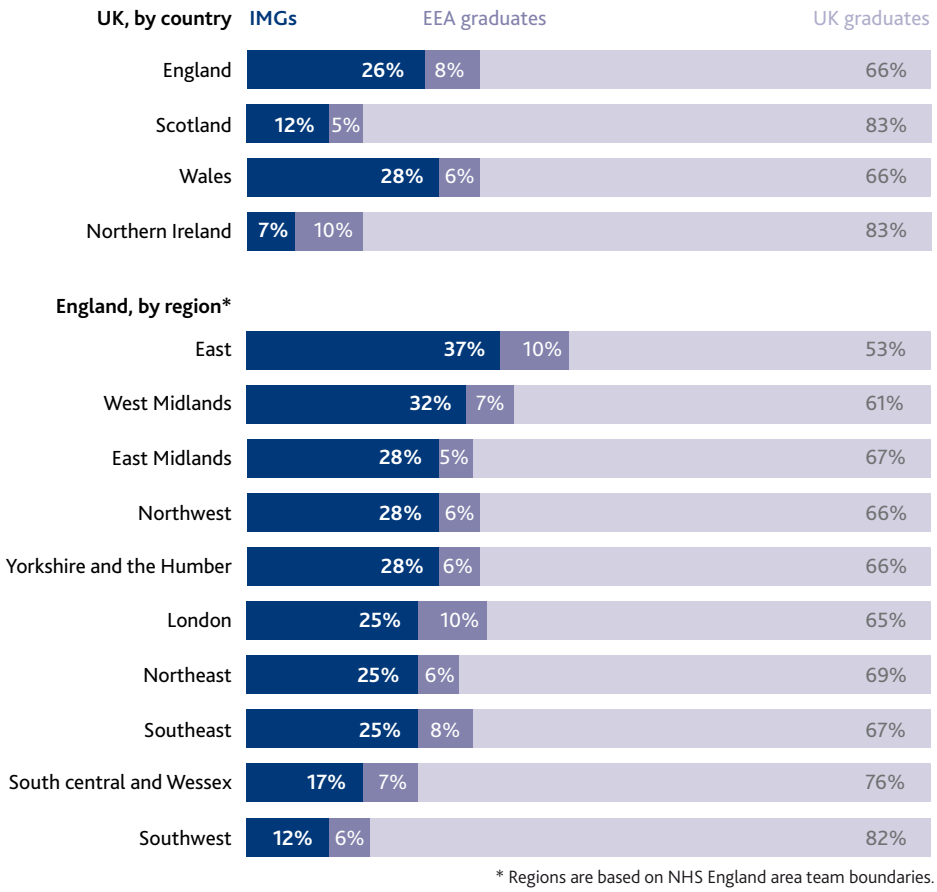
Some parts of the UK are more reliant on certain groups of doctors.

- Wales has the highest proportion of international medical graduates out of the four countries of the UK: 28% compared with 26% in England, 12% in Scotland and 7% in Northern Ireland. In England, a number of regions also had high proportions of international medical graduates, particularly the east of England and the West Midlands (37% and 32% respectively; figure 1).
- Across parts of the UK, Scotland and Northern Ireland have the highest proportion of female doctors (over 48%), compared with the east of England and West Midlands (40% and 41% respectively).

FIGURE 1: Where international medical graduates are employed across the UK

IMG = international medical graduate





* Regions are based on NHS England area team boundaries.

Medical education and training

Some areas of the UK retain more medical graduates in the local postgraduate training deanery after they leave university: Queen's University Belfast, University of Glasgow and University of Birmingham had the highest retention rates, whereas University of Dundee, University of Oxford and Bristol University had the lowest. 21% of all medical students graduating from Bristol, Oxford and Cambridge between 2009 and 2012 went on to train at the London Deanery.

Several specialties continue to face challenges in recruiting and retaining doctors, particularly in general practice, psychiatry and emergency medicine.

Complaints and complainants (chapter 2)

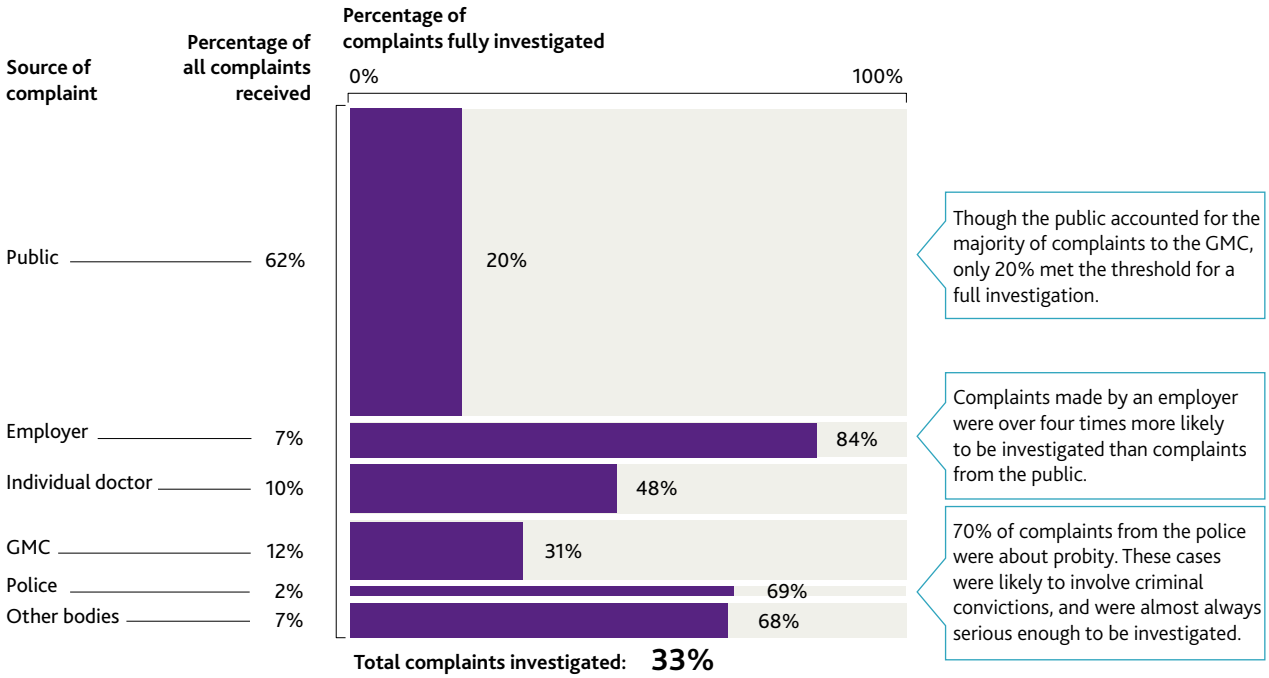
Complaints about doctors in 2012

In 2012, we received 8,109 complaints – a 24% increase since 2011 and a 104% increase since 2007.* But the rise in complaints in recent years does not necessarily indicate increasing concerns about doctors' practice and, relative to the number of interactions between doctors and patients, the number of complaints is still very small.

A third of all complaints received met the threshold for a full GMC investigation. Only 20% of complaints from the public met this threshold, compared with 84% from employers and 48% from individual doctors (figure 2).

FIGURE 2: Proportion of complaints that we investigated in 2012, by source

Data are for the 8,109 complaints about a doctor's fitness to practise.



* This year, we have separated out complaints from enquiries so that we can analyse data that raise a specific concern about a doctor's fitness to practise. We received an additional 2,196 enquiries that did not raise issues that could be dealt with by the GMC or did not raise a concern about an identified doctor.

54% of complaints were about clinical care or about both clinical care and communication with patients.* These were the most common complaints made by members of the public, employers and the GMC. By contrast, the most common complaints from individual doctors and the police were about probity (38% and 70% respectively), such as a criminal conviction or a conflict of interest.

Complaints about probity or the health of a doctor are more likely to meet the threshold for a GMC investigation than complaints about clinical care because of differences in the type of concerns they raise.

Who complains and raises concerns about doctors?

The largest source of complaints is the public. Certain groups of the public are more likely to make a complaint to the GMC.†

- Those aged 46–60 years are the most likely to complain, making 237 complaints per million people, compared with just 108 complaints per million people in the youngest group (18–30 years) and 182 per million people in the oldest group (over 60 years).
- In the age group that makes the most complaints (those aged 46–60 years), women are more likely to make a complaint to us than men: 260 versus 215 complaints per million people.
- Household income, adjusted for size, did not have a substantial bearing on an individual's likelihood to complain, but the lowest-income households (less than £15,000) are more likely to make a complaint than those earning more.

The vast majority of complaints from the public do not meet the threshold to trigger a full investigation. But, in 2012, we still investigated 989 complaints from the public – more than the number for doctors and employers combined. Many complaints from the public often be better investigated and responded to locally.

The number of complaints from employers and doctors that we investigate is also increasing. We encourage increased reporting of concerns, but there is more to be done to create a culture in which errors and complaints are viewed as opportunities for learning, and where poor practice is identified and tackled before escalation to the GMC.

The GMC itself is also a key source of concerns about doctors through our scanning of press coverage and other sources. But only 31% of the concerns raised through these sources met the threshold for full investigation. This suggests that we need to reflect on how to use our resources in this area most effectively.

* We only assign an allegation for complaints that are not closed immediately – ie those that are closed after checking for wider concerns with the doctor's employer and those that are fully investigated.

† There are a number of limitations with the demographic profile of complainants. Please see the note on data for further information (pages 60–61 in the report).

Variations in the standards of UK medical practice (chapter 3)

Complaints might be an indicator of future problems

Previous complaints may be an indicator of future problems: doctors who received no complaints between 2007 and 2011 had only a 1% risk of a full investigation by the GMC in 2012. This increased to 3% if a doctor was complained about once and 8% if the doctor was complained about twice or more, over the same period.

What is associated with a doctor's risk of being complained about?

A doctor's risk of being complained about varies across their career and is affected by their gender, where they gained their primary medical qualification and the role they work in.

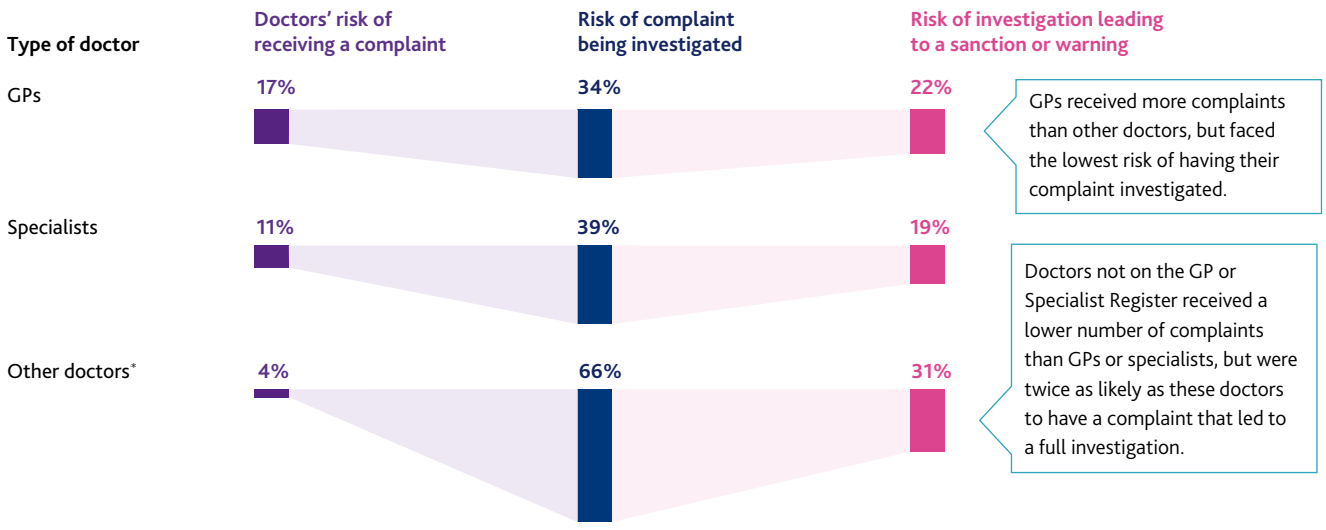
Doctors under 30 years old have a different pattern of risk than doctors aged 30 years and over: 4% versus 10% received a complaint between 2007 and 2012. But it is more likely for complaints about doctors under 30 years old to be investigated and to lead to a sanction or warning. This is because younger doctors receive fewer complaints about clinical care, and so receive a higher proportion of complaints about probity or their health, both of which raise issues that are more likely to be fully investigated.

A higher proportion of general practitioners (GPs) are complained about than other doctors, but doctors who are on neither the GP nor the Specialist Register are more likely to have complaints against them investigated (figure 3).

The risk of doctors aged 30 years and over being complained about is affected by their personal characteristics.

- Male doctors were around twice as likely as female doctors to be complained about, irrespective of the register they were on. For example, 22% of male GPs received a complaint compared with just 11% of female GPs between 2007 and 2012.
- The proportion of doctors over 50 years old who received a complaint was higher than for doctors aged 30–50 years. This was particularly true for GPs.
- International medical graduates received a higher proportion of complaints than UK or EEA graduates. This was particularly true for GPs: 25% of international medical graduates received a complaint compared with only 15% of UK graduates and 17% of EEA graduates.

FIGURE 3: Risk of different types of doctors aged 30 years and over receiving a complaint, of those complaints being investigated and of those investigations leading to a sanction or warning during 2007–12



* Doctors not on the GP or Specialist Register.

Groups of doctors with high risks of receiving a sanction or warning

During 2007–12, only 1% of doctors had an incident reported to us that merited a sanction or warning. But there were some groups of international medical graduates and EEA graduates that stood out as having had more than double the risk of receiving a sanction or warning in this period:

- male doctors over 50 years old who were EEA graduates
- male doctors over 50 years old who were international medical graduates
- male GPs aged 30–50 years who were EEA graduates
- male GPs aged 30–50 years who were international medical graduates.

How our data might contribute to understanding system risks (chapter 4)

The variation in complaints across the UK

There continued to be a variation in the number of complaints that were received and investigated across the four countries of the UK in 2012 (figure 4).

What do our data tell us and others about the quality of care at NHS trusts in England?

We did an exploratory analysis to understand whether our complaints data or national training survey results are related to external data about National Health Service (NHS) trusts in England. This work can help us and others begin to understand how our data may contribute to understanding and potentially identifying risks in the future.

We found a number of statistically significant correlations between our data and other data about NHS trusts.

FIGURE 4: Complaints in the UK in 2012, by country

Country	Number of all complaints per million people in 2012: Complaints fully investigated	Number of all complaints per million people in 2012: Complaints not fully investigated	Total	Percentage of complaints coming from the public
England	44	85	129	62%
Scotland	30	63	93	60%
Wales	35	60	95	64%
Northern Ireland	24	70	94	57%
UK average	42	82	123	62%

Numbers are rounded so may not sum exactly.

Addressing the challenges facing medical practice (chapter 5)

We are committed to changing the way we work with doctors to better support them and enable them to provide the best possible care.

Below we set out four areas that we have identified in the report as needing further debate and action to address some of the challenges doctors face.

The changing shape of the medical workforce

Successful workforce design requires both national and local solutions. At the national level, greater flexibility in training and career paths is urgently required.

At the local level, the challenge of attracting and retaining sufficient numbers of doctors with the right mix of skills needs to be addressed. This is particularly relevant where the healthcare service is relying on certain types of doctors, such as international medical graduates who may be declining as a proportion of the workforce.

As part of the information required for revalidation, we are committed to gaining a better understanding of where doctors are working and in which settings. This will provide new insights about the shape of the workforce across the country.

Supporting complainants

Helping patients and their carers, relatives and friends to navigate the complaints maze remains a substantial challenge – this is indicated by the large number of complaints to us that do not meet our thresholds for investigation.

We need to work with patients so that they know what to expect from their doctor and where different types of complaints are best directed.

Employers and doctors need to be encouraged to continue raising concerns.

Variation in the risk of being complained about or receiving a sanction or warning from the GMC

There are several individual and organisational factors that increase the risk of poor practice. This year's analysis has identified particular characteristics associated with higher risk. We and others need to understand why certain groups of doctors face higher risks of falling below our standards.

This will help us to identify where we may need to change the relationship we have with doctors so that we are better at supporting them in the workplace.

The interactions between professional and system risks

The correlations identified between our data and data about NHS trusts confirm the importance of organisations working together to share data and intelligence about the quality of care.

We need to understand more about the organisational factors that affect the quality of medical practice and training, and the implications that these might have on a doctor's ability to meet our standards.

Read the full report and tell us what you think about our findings at **www.gmc-uk.org/somep2013**.

Published October 2013
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The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

Code: GMC/SOMEP2013-sum/1013

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