General Medical Council

The state of medical education and practice in the UK

2014

Working with doctors Working for patients

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Introduction

This is our fourth annual report on the state of medical education and practice in the UK. It sets out what is happening in the medical profession and considers some of the key issues the profession faces, using General Medical Council (GMC) and other data.

A rapidly changing environment

This year's report comes at a time when doctors and other healthcare professionals are facing a changing and in many ways challenging work environment. In addition to significant medical, technological and scientific advances, and higher patient expectations, it is hard to overstate the impact of a growing population of very elderly people and increasingly complex medical conditions.

Large parts of the healthcare systems in all parts of the UK either are trying to embed recent organisational change or have impending changes in the pipeline. The financial position is more difficult than it has been for many years, not only because of rising demand and little or no growth in budgets, but because there has been a sustained period of austerity over the past few years. With cuts of 10% in National Health Service (NHS) commissioning budgets planned for 2015–16 in England, and similar pressures in Northern Ireland, Scotland and Wales, maintaining quality and safety will be a major challenge.

It has also been a period of reflection and some soul searching, prompted by high profile public inquiries. The most significant was the inquiry into Mid Staffordshire NHS Foundation Trust,[1] which has been followed up by reports a year on from the Department of Health[2] and the Nuffield Trust,[3] and a parliamentary debate. Similar issues have been raised in other parts of the UK, leading to other major investigations. In Northern Ireland, the Regulation and Quality Improvement Authority review looked into arrangements for unscheduled care,[4,5] and the inquiry into hyponatraemia-related deaths is expected to be published by the end of this year. In Wales, the inquiry into the Healthcare Inspectorate Wales is expected to look at the extent to which it is fit for purpose, and the independent *Trusted to Care* review made 18 recommedations on improving quality and care across Wales. In Scotland, the Vale of Leven hospital inquiry has investigated the occurrence of *Clostridium difficile* infection from 2007 onwards. There has been an investigation into patient safety and quality of care in NHS Lanarkshire, and into the management of NHS waiting lists at NHS Lothian.

It is perhaps too early to reach any definitive conclusion about the impact of all these reports. Many of the fundamental issues – concern that care is less compassionate and that the most vulnerable people are too often neglected – are not new. The ability of staff to raise safety concerns, together with more general concerns about how to create a culture where safety dominates, has also dominated the debate. In England, there has been a major emphasis on inspection and the Care Quality Commission now has wider powers, including inspecting general practitioner (GP) surgeries. The government and healthcare providers are increasingly recognising that safe care cannot always be maintained with low staffing levels although, in parts of the country at least, more staff will almost certainly mean larger deficits.

The changing patient population needs to be reflected in doctors' education and practice

In medicine, a debate has begun into the best way of organising postgraduate training for the 21st century. The independent Shape of Training review argued that doctors need to be trained in a new way to deliver general care in broad specialty areas across a range of different settings. The review recommended that, after broad specialty training, doctors should go on to train in more specialised areas where there are local patient and workforce needs. And it called for more opportunities for doctors to change roles and specialties throughout their careers.

Meanwhile, the ongoing debate about the configuration of services continues, with questions around whether smaller district general hospitals are sustainable, and how to better join up hospital and community services.

Risk-based regulation of individual cohorts of doctors

Additional pressures clearly create more risk of stress and poor performance. In reality, the number of doctors falling below minimum professional standards remains very small, although there are groups of doctors that seem to be at higher levels of risk. The more that the GMC, the medical profession, employers and others can do to identify and understand the nature of those risks, the more it should be possible to ameliorate them.

Modern regulation requires the intelligent use of data – this should help all of us understand future patterns of risk more effectively. We will be reporting on this in subsequent editions of this report. We have begun to develop a longer-term data strategy and, working with others including other regulators, we hope this will lead to more targeted intervention to identify and support areas of weakness.

At the same time, regulators of healthcare professionals around the world are seeing a rise in complaints, especially from patients. There is no evidence that this is the result of poorer care and it seems much more likely to be the product of changing expectations – a less deferential society in which 'doctor knows best' no longer holds sway. The massive impact of the digital age has given patients access to information about their own conditions, about protocols and treatments, and about the performance of healthcare institutions and, in some cases, individuals. It has also made access to institutions much easier and in particular made it much easier to raise a complaint. This is all to be welcomed – it is part of the changing of the power relationship between patients and healthcare professionals. In the vast majority of cases, it will see the emergence of a genuine partnership between healthcare professionals and patients. But it does raise questions about how concerns are dealt with.

There has been a staggering rise in complaints to the GMC. Although the rate of increase slowed in 2013 to about 5.7% per year (from 25% in 2011 and 24% in 2012), the level is now 64% above that in 2010. The legal framework that governs these complaints has not changed. A very high proportion of complaints to us do not lead to a sanction or a warning for the doctor. This does not mean that all these complaints are unimportant – but it does mean that they should be dealt with elsewhere and should not have ended up with the UK regulator. The GMC, government, employers and the medical profession have not yet succeeded in dealing with this – complainants have a right to be directed to the organisations that can deal with their complaints most efficiently and effectively. Encouraging concerns to be raised by patients and relatives is vital in an industry where safety is critical, such as healthcare, but part of that is ensuring that they go to the right place. The data presented in this year's report are further evidence of the importance of urgently achieving effective policy development in this area.

The draft Law Commission bill,[6] if converted into legislation, would go some way towards addressing this issue by giving regulators greater flexibility in handling complaints. The key to this will be to make sure complaints and concerns are handled appropriately at the right level. We will do everything we can to encourage the introduction of the bill in the next Parliament.

Doctors from ethnic minorities and who come from outside the UK

We commissioned an independent report earlier this year, which revealed that the vast majority of doctors, including black and minority ethnic (BME) doctors,* are confident in how the GMC carries out its role. Nevertheless, the report showed that there were underlying concerns among some, and we acknowledge that more needs to be done to build trust among certain groups of doctors.

One particular issue evident in our data this year – and the subject of high-profile debate – is that BME doctors and doctors who gained their primary medical qualification outside the UK often have a higher than average likelihood of receiving a sanction or a warning in our fitness to practise procedures. We have examined why fitness to practise outcomes differ between groups of doctors: whether this is due to differences in the type of allegations or to the fact that some cohorts are better able to show insight and that they are fit to practise in the future. Although the samples are quite small, there is some evidence that these differences play a part in fitness to practise outcomes, which has implications for the type of support that we and others need to consider in the future.

Some of the data in this year's report validate some of the concern expressed in recent years about doctors who gained their primary medical qualification outside the UK – particularly European Economic Area (EEA) graduates† – being at higher risk of concerns about their fitness to practise. As these data have become better understood, a number of policy

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

† 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.

developments have occurred (such as tighter controls on language testing of EEA doctors) or are under active consideration (such as the introduction of a national licensing exam for all doctors, irrespective of where they obtained their undergraduate qualifications. Our Council is considering proposals in this area).

Greater transparency and cooperation between regulators

In recent years, we have seen the danger of risks not being identified early[7] to the quality of care and patient safety. Identifying risks earlier, and intervening to mitigate those risks, requires more understanding and sharing of data, both between regulators and between regulators and healthcare providers.

The Mid Staffordshire inquiry in particular highlighted the danger of organisations operating in silos and the vital importance of regulators and others working together more effectively in the future.[1] We now have an information sharing agreement[8] with the Care Quality Commission and we are developing similar arrangements with other system regulators throughout the UK.

It also seems inevitable and desirable that there will be greater cooperation between regulators of healthcare professionals. This would be facilitated by the draft Law Commission bill becoming law, allowing all regulators of healthcare professionals to work under the same legislation. There are plenty of opportunities to take this forward, recognising that doctors and other healthcare professionals nearly always work in multidisciplinary teams where the members are very dependent on each other.

For example, we are developing joint approaches to shared issues: in the autumn, we will issue a joint statement on the professional duty of candour with other regulators of healthcare professionals in England, we are launching a consultation on explanatory guidance on being open and honest when things go wrong, which we developed in partnership with the Nursing and Midwifery Council.

This joint working has developed at the same time as a widespread change in approach towards transparency of data. Calls for more openness in areas such as publishing all clinical trial data have led to made significant inroads in this regard. The Royal College of Surgeons has started publishing performance data for individual surgeons,[9] and there has been a promotion of hospital-level data.

Our report is part of our continuing aim to improve the transparency and sharing of data. We have also begun to publish data in several new areas, including fitness to practise data by secondary care location, as well as data on hospitals and other sites where we have concerns about medical education. It is too early to include analyses of these new datasets in this year's report, especially as the data need to be interpreted with caution to avoid jumping to the wrong conclusions.

The medical profession and the health service need to agree how such information should be used and discussed. Recent data suggest that the hospitals with a bad reputation from previous situations unsurprisingly find recruitment of talented staff difficult in a period when vacancy rates are generally high and doctors have a choice of where to go.* This could leave hospitals in a vicious circle and is certainly not what we want to achieve by sharing these data.

* For example, Mid Staffordshire NHS Foundation Trust has a 20% vacancy rate for consultants, Barking, Havering and Redbridge University Hospitals NHS Trust has a 13% vacancy rate and United Lincolnshire Hospitals NHS Trust has a 10% vacancy rate.

The impact of revalidation on patient safety

One of the greatest innovations in medical regulation over the past two years has been introducing revalidation – the system of regular checks on doctors' performance, which aims to provide greater assurance that each doctor is competent, up to date and able to deliver safe and effective care. There is as yet little in this report on its impact – we are still at the start of a new process that is more ambitious than anything that has been attempted elsewhere. But, in future reports, we will reflect on the impact of this process on medical practice and importantly on clinical governance throughout the healthcare systems of the UK.

The early signs are positive. Organisations and responsible officers report that the new arrangements have gained traction, with rising rates of appraisal, and improved support and oversight for doctors who have previously been ignored. There is growing awareness among those outside medicine that this is not just a matter for doctors, but a key process for any medical organisation that is committed to patient safety and high-quality care. We have just commissioned an independent long-term evaluation of revalidation that we will respond to as findings emerge.

What we look at in this year's report

We have taken several departures from previous editions of this report.

Chapter 1 gives a more comprehensive analysis of our data on the medical profession and education than previously, with a wider range of data on regional and country differences. It is intended to be a reference chapter that informs subsequent chapters of the report and will also, we hope, be useful to those examining particular issues. We have organised it in this way following feedback from our readers.

The first seven sections of chapter 1 present data separately on medical students, doctors in training and on GPs, specialists and other doctors, showing the changing demographic make-up of the medical profession, who is joining and leaving the register and where doctors are working across the UK. This provides important evidence in a profession where primary care has recruitment issues, and when specific parts of the UK are finding it harder to recruit than others.

The later sections of chapter 1 show in much more detail than previously our fitness to practise data, summarising the volume of complaints, investigations and the outcomes of investigations in 2013 and how this has changed since 2010. We also examine, using pooled data over four years, where complaints come from, what they are broadly about (the types of allegation involved), and how the risk of being complained about, being investigated, and receiving a sanction or a warning varies between different cohorts of doctors.

In **chapter 2** we continue to develop our understanding of risk by examining in more detail the type of cases that lie behind the data. First, we analyse cases with different types of allegation attached to them – in particular drawing a distinction between cases involving a doctor's health, criminal convictions, honesty and fairness issues and aspects of professional standards and clinical competence. Second, an initial small-scale analysis looks at how showing insight, apologising, taking remedial action and having a legal representative affect fitness to practise panel hearings, and whether the doctor receives a sanction or a warning.

We also have more information on specialties than previously. We examine data relating to cosmetic surgeons, an area of high concern in recent years, and identify locums as a particular area of concern despite the high quality of some. Unfortunately, there remains a lack of specific data on this group, but we are pleased to note the Department of Health's review of this area, which we believe will be published after we go to press.

Chapter 3 gives a fuller analysis of the education of medical students and doctors than in previous years, with particular emphasis on how prepared doctors are for practice after leaving medical school, and whether there is a correlation with their later performance.

Chapter 4 examines the issues that have been raised through feedback to our liaison services and offices in Northern Ireland, Scotland and Wales, rather than relying primarily on quantitative data. This relatively new intelligence provides some evidence of what the medical profession is concerned about and chooses to raise with the GMC as the national regulator. For example, GPs in England are concerned about balancing conflicts of interest between their role on a clinical commissioning group and their role as a doctor, and about balancing patient and wider public interests with limited budgets. We believe that highlighting these issues, as they are raised to us, is as important as analysing historical quantitative data and trends to help us understand how challenges are being dealt with on the ground.

Each chapter is very different. We hope that regulators, patient groups, employers, doctors, workforce planners and policy makers will find much to take from the whole report. It shows a varied, vibrant and sometimes unexpected profession – one that we can be proud of, but, as recent inquiries have shown, one facing challenges that we must never be complacent about identifying and tackling.

Niall Dickson
Chief Executive and Registrar, GMC

Executive summary

This is our fourth annual report on the state of medical education and practice in the UK. It sets out what is happening in the medical profession and considers some of the key issues the profession faces.

Despite growing demands and expectations, the medical profession in the UK is still very highly regarded,[10] and the quality is such that both medical education* and practice†,‡ are held in high esteem across the world. In a report that inevitably concentrates on risks and challenges, it is important that this overall message is borne in mind.

The medical workforce – doctors and medical students – has a central role in helping to meet these challenges. This report looks at the shape and size of that workforce across the UK, at the current state of medical education, and at how medical education needs to adapt to this rapidly changing environment to create even more adaptable doctors in the future. We also examine the risks of different doctors failing to meet our standards, and the challenges doctors tell us they are facing now and in the immediate future.

We hope that regulators, patient groups, employers, doctors, workforce planners and policy makers will find the data and analysis in this year's report useful.

Our data on medical education and doctors working in the UK (chapter 1)

Figure 1 (page 11) sets out the size of the medical workforce and some characteristics of licensed doctors and medical students in the UK.

In 2013, female doctors made up 44% of licensed doctors, 49% of general practitioners (GPs) and 32% of specialists. During 2010–13, the number of female

* Three of the top four universities for clinical, pre-clinical and health courses in the 2013–14 Times Higher Education world university ranking are from the UK.[11]

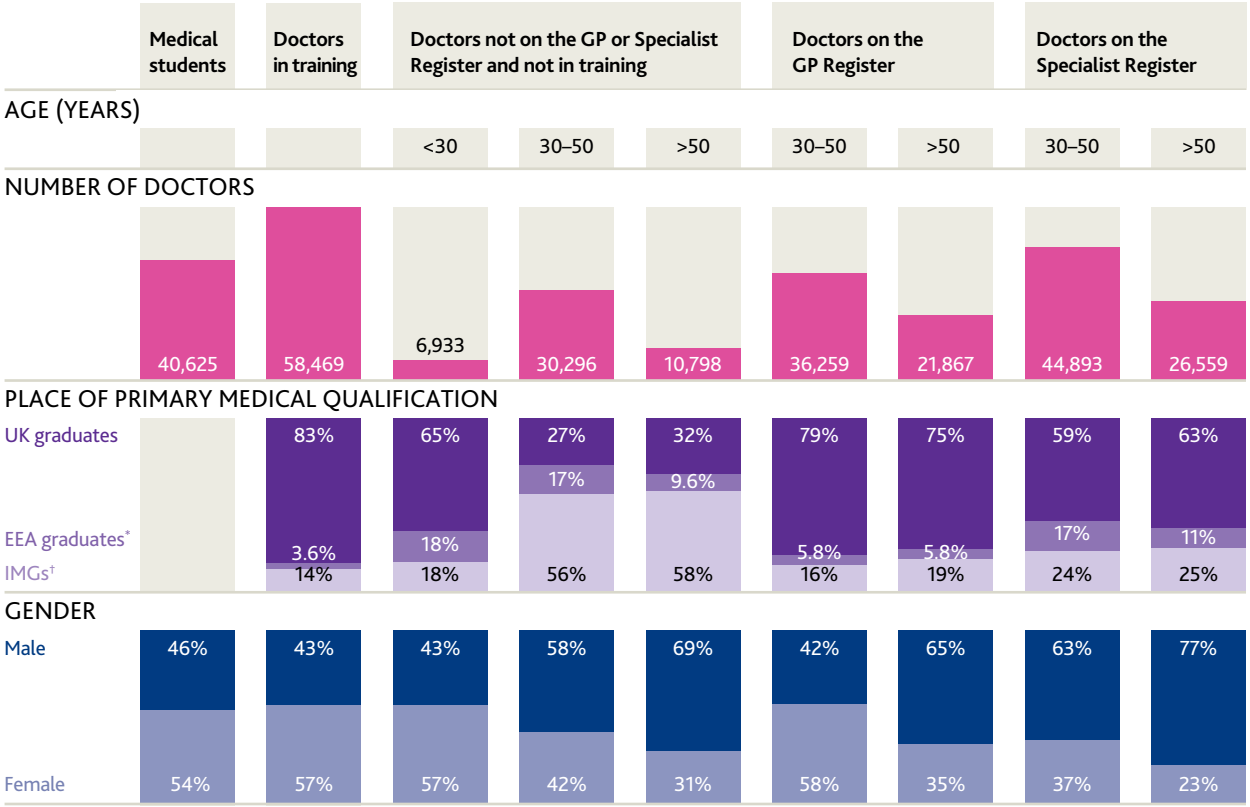
† Behind the USA, England has the highest number of clinical medicine citations.[12]

‡ The Washington based Commonwealth Fund published a report ranking healthcare systems on various metrics.[13] The UK came top overall and was first in every measure of the quality of care and efficiency.

doctors on the Specialist Register increased twice as fast as the number of male doctors. In surgery, the number of female doctors increased by 42%, compared with 12% for male doctors, but, by 2013, 90% of surgeons were male. Emergency medicine also saw a disparity: the number of female doctors grew by 44%, compared with 28% for male doctors, meaning female doctors accounted for a third of doctors in emergency medicine in 2013.

In 2013, we knew the ethnicity of 82% of licensed doctors on the medical register. 39% of those doctors in England were black and minority ethnic (BME),‡ compared with 32% in Wales, 19% in Scotland and 10% in Northern Ireland. 34% of medical students were BME. Overall, 13% of the UK population is BME.

FIGURE 1: Personal characteristics of licensed doctors on the register and medical students in 2013



* European Economic Area (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.

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

Specialties

Different specialties have a different demographic profile. Overall, 37% of doctors on the Specialist Register in 2013 were over 50 years old. Occupational medicine and public health had more doctors over 50 years old than other specialties, while emergency medicine had a younger workforce, with only a quarter over 50 years old (figure 21, page 52).

The number of doctors on the Specialist Register continues to grow – the largest rise was 21% among EEA graduates during 2010–13, so they accounted for 15% of specialists in 2013. IMGs were most strongly represented in obstetrics and gynaecology, psychiatry, paediatrics and pathology.

In most specialties, BME doctors made up 25–35% of the population. Obstetrics and gynaecology (44%) and paediatrics (37%) had a larger proportion of BME doctors, while occupational medicine had the highest proportion of white doctors (85%).

Where the workforce comes from

In 2013, there were 58,469 doctors in training – five out of six were UK graduates, and around one in 30 were EEA graduates. 63% of all doctors were UK graduates, 10% were EEA graduates and 26% were IMGs.

In 2013, more EEA graduates joined the medical register than IMGs. A third of non-UK graduates who joined the register were from southern Europe, and a fifth were from Italy and Greece alone. The number of doctors who joined the register from Ireland also increased by over 50% compared with five years before – they made up 3% of those joining the register in 2013.

The number of IMGs joining the medical register has levelled off – increasing by just 0.3% between 2012 and 2013 – possibly as a result of changes to visa requirements.

Differences across the UK

Medical students are concentrated in areas of high population. In 2013, the number of medical students in London (9,174) was greater than the combined number for Northern Ireland, Scotland and Wales combined (8,241).

For the first time we can now locate where doctors work for around 90% of the medical register (box 1, page 23). For most doctors, we identified location from the organisation they are connected to for revalidation; where this information was not available or geographically specific, we used their employer's address or their correspondence address.

There is little variation in the ages of doctors across the UK, but there are variations in gender and ethnicity. Scotland (52%), London (51%) and Northern Ireland (51%) had a higher proportion of female doctors aged 30-50 years in 2013, whereas the Midlands (43%), north of England (45%) and Wales (46%) had a lower proportion. 39% of doctors in England and 32% in Wales were BME, compared with only 10% in Northern Ireland and 19% in Scotland.

Developing our understanding of risk (chapters 1 and 2)

It is important to understand whether some doctors are more likely to face complaints and investigations, or to receive sanctions or warnings from the GMC. A better understanding of this should help determine whether any action can be taken to reduce the risk amongst these doctors in future.

To this end we pooled data over four years (2010–13) to analyse more than 28,000 complaints made to the GMC about licensed doctors. Chapter 1 presents our data on doctors who have been complained about, had the complaint investigated, and received a sanction or a warning (summarised in figure 2, page 14), and chapter 2 looks at which groups are most at risk and why.

Groups of doctors being complained about, investigated and receiving sanctions or warnings

Complaints and the outcomes of investigations

Non-UK graduates were more likely to be complained about and to have that complaint investigated than UK graduates. When looking at the outcome of the investigation, white UK graduates had a lower chance of receiving a sanction or a warning than all other groups.

For all UK graduates, BME doctors were 50% more likely to receive a sanction or a warning than white doctors. This rose to twice as likely for those aged 30–50 years.

Among white doctors aged over 50 years, EEA graduates were over twice as likely as UK graduates to receive a sanction or a warning.

Groups particularly likely to get a sanction or a warning

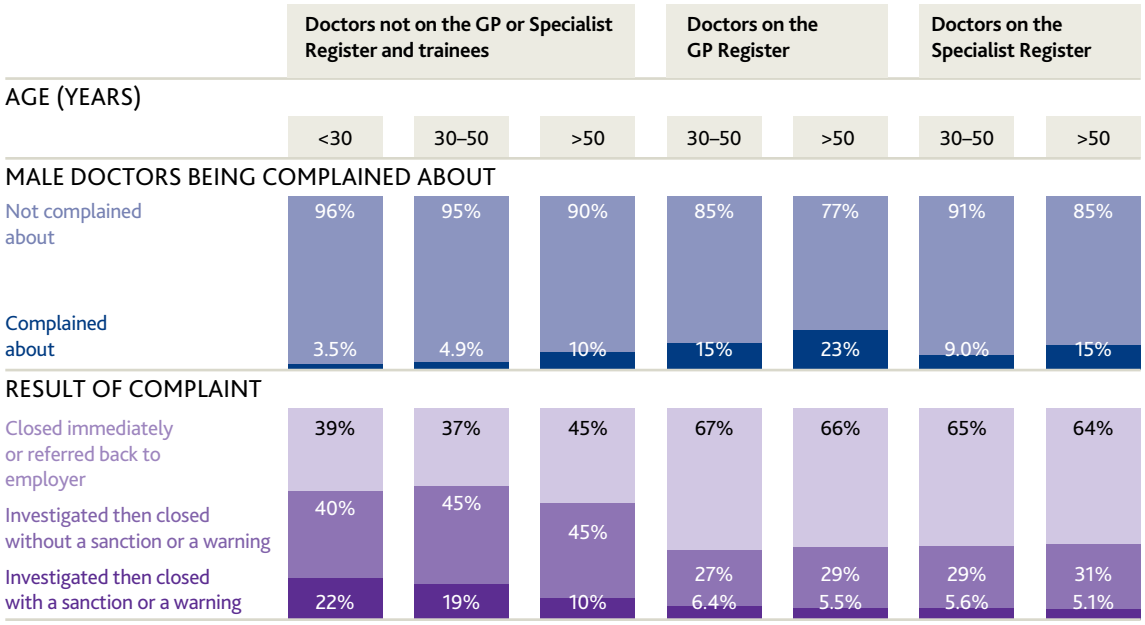
Some groups of doctors were more likely to receive a sanction or a warning. Four groups stood out: male doctors over 50 years old who were EEA graduates or IMGs, and male GPs aged 30–50 years who were EEA graduates or IMGs.

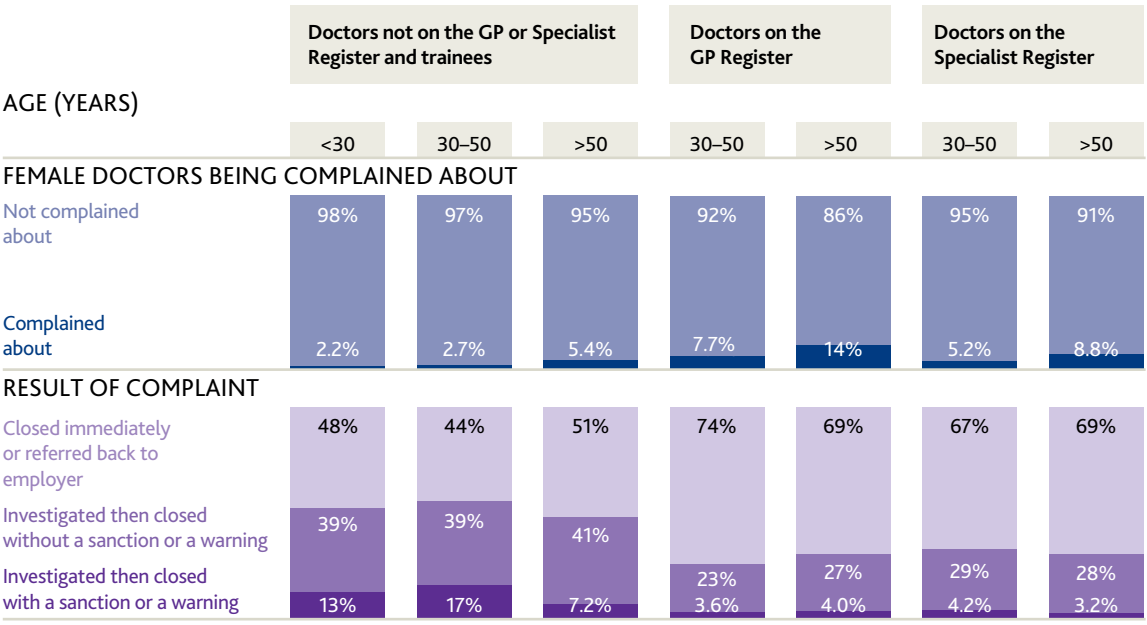
Specialties

Doctors working in some specialties were more likely to be complained about and to have the complaint investigated (figure 44, page 82), and to receive a sanction or a warning (table 9, page 93). It seems much more likely to be the nature of the specialty than the demographic characteristics of the doctors that work within them that lead to an increased likelihood in some specialties.

- Doctors in three specialty groups – psychiatry, obstetrics and gynaecology, and surgery – were more likely to be complained about and to receive a sanction or a warning.
- Plastic surgeons, including many cosmetic surgeons, were four times more likely to be complained about than other surgeons, and nine times more likely to receive a sanction or a warning.

FIGURE 2: Proportion of male and female doctors who were complained about, had the complaint investigated and received a sanction or a warning during 2010–13





Locums

Doctors who were attached to a locum agency in 2010–13 were more likely to have their complaints investigated, and to receive a sanction or a warning. There is more work to be done to investigate and understand the patterns these data show.

Different types of allegation contribute to some groups having a higher chance of receiving a sanction or a warning

At the start of an investigation, we decide what types of allegations are raised by the concern. Certain allegations – such as those involving a doctor's health or criminality – have a higher probability of resulting in a sanction or a warning.

The data suggest that some groups of doctors are more likely to be erased or suspended from the medical register, or receive another sanction, because they get into difficulty in particular areas, not because there is a general tendency for that group to receive more serious sanctions when they are investigated.

In general, a higher proportion of cases about non-UK graduates and BME doctors involved allegations about criminality, and a higher proportion of complaints about them were from employers. On the other hand, relatively more cases about white UK graduates involved allegations about clinical competence – particularly from the public – which have a lower probability of leading to a sanction or a warning.

Place of primary medical qualification and ethnicity of doctors at panel hearings

This year, we analysed the panel judgments on all 147 cases closed in 2013 that did not involve a criminal conviction or concerns about a doctor's health.

A higher proportion of UK and EEA graduates' cases tended to involve allegations about honesty, fraud and fairness than IMGs' cases. EEA graduates tended to have a higher proportion of cases about poor diagnosis and examination than either UK graduates or IMGs.

A lower proportion of UK graduates who had a panel hearing were erased compared with non-UK graduates – five out of 48 (10%) versus 29 out of 99 (29%).

Showing insight, apologising and remediating

The panel takes into account whether the doctor has shown insight, sometimes through making an apology or attempting to remediate the concern, when deciding the outcome of a case. In some cases, lack of insight appeared to have a major influence on whether a doctor was erased from the medical register or given a less serious sanction.

Overall, doctors who showed insight were almost ten times less likely to be erased than those who did not – 50% of doctors who did not show insight were erased, compared with only 5.5% of those who did show insight. UK graduates were most likely to have demonstrated insight, alongside apologising or remediating the concerns. This may in part account for why some cohorts of doctors are more likely to get a serious sanction than others.

Preparing doctors through medical education and training (chapter 3)

This year, we have focused on how prepared young doctors are for practice after leaving medical school, and whether there is a correlation with later performance. In 2013, there were 40,625 medical students. There were also 7,759 doctors in their first year of foundation training following medical school (F1 doctors), 7,636 in their second year of foundation training (F2 doctors), 10,746 doctors training to be GPs and 32,328 doctors training to be specialists.

Preparedness of foundation doctors

Our 2014 national survey of doctors in training found that seven out of ten F1 doctors believed medical school prepared them to work as a doctor in the UK health system. Equal proportions of male and female doctors felt prepared.

However, there was still some concern among both trainers and employers about how well prepared doctors in training actually are.

EEA graduates felt less prepared than either UK graduates or IMGs for their first foundation post in the 2014 national training survey – 42% of EEA graduates felt prepared, compared with 58% of IMGs and 70% of UK graduates. A higher percentage of younger doctors (under 30 years old) and white F1 doctors believed they were adequately prepared, compared with those aged 30 years and over and BME F1 doctors.

What they feel unprepared for

Medical students and F1 doctors were worried about some specific aspects of their work, particularly how to prescribe properly. Some also felt unprepared for communicating with patients, and frequently reported distress during and after particular incidents. Trainers have reported concerns about F1 doctors carrying out clinical procedures such as venepuncture, cannulation and arterial blood gas tests. The literature in this area also suggests that doctors in training are relatively unprepared for reporting and dealing with error and safety incidents.

Variation between UK medical schools

There is unsurprisingly variation between medical schools, all of which have their own curricula and assessment systems. Graduates of different medical schools vary in the degree of preparedness they feel, and in the specialties they go on to train in.

Preparedness

When asked in the 2014 national training survey whether they were adequately prepared by their medical school, the proportion of graduates who agreed or strongly agreed varied from 62% to 97%. Some medical schools have seen their graduates preparedness increase more than others – some schools saw a rise of over 50% in the proportion of graduates who felt prepared for their first F1 post between 2009 and 2014.

Specialties that doctors choose

A higher proportion of graduates from Oxford and Cambridge medical schools became physicians or surgeons, whereas other schools produced a higher percentage of GPs.

Issues being raised to us by doctors and others in the UK (chapter 4)

This year we report on concerns that doctors and others have chosen to raise with the GMC, as the national regulator, over the past year or so, which may become issues affecting patient safety and medical practice in the future.

Doctors are still worried about raising concerns

The feedback through our regional liaison service suggests a continued lack of awareness of how to raise concerns and that doctors feel they might not be supported when they do. We receive regular requests for advice on raising concerns, although the most frequent requests to our Standards team are for advice on standards of clinical care, confidentiality and prescribing.

A new confidential helpline launched in December 2012 had received 1,235 calls by April 2014, from which 191 complaints, involving 237 doctors, had yielded 81 investigations.

Pressures on primary and secondary care

Feedback from our liaison services and offices across the UK shows that both primary and secondary care are under pressure. But we know more about the issues in primary care because we receive more detailed feedback from GPs than from doctors in secondary care. Although there were some differences in the pressures on GPs between rural and urban areas, there were many general concerns about GPs having too much work and being at risk of burning out.

Doctors report high levels of stress. In one part of the UK, the proportion of GPs presenting to local occupational health services increased nearly five times from 2000 to 2012 and, in another part of the UK, 2013 was described as the busiest year for two decades for the number of GPs burning out from stress.

Other issues raised to the GMC

Standards of end of life care

End of life care is one of the most challenging areas of medicine. We get a large number of questions and requests for guidance, particularly about the ethical considerations and logistical difficulties around managing care outside of hospitals. Even experienced doctors say they can sometimes lack the support, confidence or skills needed to effectively communicate on these distressing issues.

Balancing conflicts of interest

Ethical concerns have been raised about the commissioning of services, particularly in England where doctors balance commissioning and care provider roles. Guidance cannot solve conflicts of interest, only help doctors to manage them, and we will review whether there is more we can do to support doctors.

Use of social media by doctors

Medical students and doctors are concerned about using social media unguardedly, especially to voice how they are coping professionally and concerns about time pressures, tiredness on the wards and making clinical mistakes.

Patient confidentiality and use of patient data

We consistently receive a lot of queries about protecting and sharing patient data, and will be consulting on an updated edition of our guidance on this in 2015.

Chapter 1: Our data on medical education and doctors working in the UK

In this chapter, we give an overview of our data about doctors working in the UK, medical education and our fitness to practise processes. Some of the key facts we highlight form the basis of further analysis in later chapters, which also draw on data from other sources including qualitative intelligence.

This year, we have included more data on the different parts of the UK (box 1, page 23), on medical schools and training, on individual specialties, and on the impact of ethnicity on doctors working in the UK.

We have highlighted where you can also find additional data in a webappendix at **www.gmc-uk.org/somep2014/webappendix**.

Overview of the data in this chapter

The shape of medical education and the profession

Sections 1–2 give an overview of the shape of the medical register and the numbers of doctors who have a licence to practise in the UK. Licensed doctors form the basis of most of the remaining data in this chapter.

- **Section 1:** The medical register and licensed doctors (page 24)
- **Section 2:** Licensed doctors (page 27)

Key facts

- The growth in licensed doctors has slowed since the introduction of revalidation.
- The number of specialists is growing faster than other doctors.
- Scotland has more doctors per 100,000 people than other UK countries.

Sections 3–5 present data about the different stages of a doctor's career.

- **Section 3:** Medical education and training (page 30)
- **Section 4:** Doctors under 30 years old who are not in training (page 40)
- **Section 5:** Doctors aged over 30 years who are not in training (page 42)

We look at the changing demographic profile of doctors at each of these stages in terms of gender and ethnicity, as well as differences between graduates of UK medical schools, graduates from the rest of the European Economic Area (EEA)* and international medical graduates (IMGs)† from other parts of the world.

Key facts

- Medical students are concentrated in particular parts of the UK.
- Some parts of the UK are more reliant on doctors in training than others.
- The number of doctors not in training under 30 years old is increasing.
- London, Northern Ireland and Scotland have more female doctors.
- Female doctors form a higher proportion of GPs and a lower proportion of specialists.
- Two thirds of doctors who are not GPs or specialists and not in training did not graduate in the UK.
- A higher proportion of specialists than GPs are IMGs.
- There is a higher proportion of UK graduates in Northern Ireland, Scotland and the southwest of England.

* 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.

Section 6 (page 50) looks at differences in the age, gender, ethnicity and place of primary medical qualification of doctors across different specialty groups.

Key facts

- The number of doctors on the Specialist Register grew by 12% in three years from 2010 to 2013.
- The number of specialists in emergency medicine has grown the fastest.
- Some specialties have much older age profiles.
- The growth in specialists has been driven by doctors who graduated outside the UK.
- The proportion of black and minority (BME)* doctors is higher among obstetrics and gynaecology specialists (44%) and paediatricians (37%).

Section 7 (page 54) looks at trends among doctors joining and leaving the medical register since 2008. This includes the balance of leavers and joiners among different cohorts of doctors, including UK graduates, EEA graduates and IMGs. We also look at which countries EEA graduates and IMGs are coming from, why doctors are leaving the register, and which countries doctors are going to if they are leaving the UK to work elsewhere.

Key facts

- The number of EEA graduates joining the UK medical register is greater than the number of IMGs.
- The doctors joining the register aged 30 years and over are disproportionately non-UK graduates.
- More doctors come from southern Europe than from south Asia.
- The reasons for leaving vary by age and where a doctor gained their primary medical qualification.
- The indications are that the number of UK graduates leaving to work abroad is increasing.

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

Revalidation

Since the end of 2012, doctors have been required to revalidate every five years to demonstrate that they remain fit to practise medicine. As a result, so far we have just over one year's worth of data on doctors who have revalidated, and **section 8** (page 60) summarises the numbers involved and shows the variation in the proportion of different cohorts who have had their revalidation deferred.

Key facts

- The GMC had received 38,486 revalidation recommendations for doctors not in training by the end of April 2014.
- Certain groups have a higher probability of deferral.

Fitness to practise

Section 9 (page 62) shows how we handled the complaints we received in 2013 and what the outcomes of the cases were.

Key facts

- The increase in complaints is slowing, but the number of complaints we received in 2013 was still 64% more than in 2010.
- The number of full investigations is increasing.
- Half of the complaints received by the GMC are closed immediately.
- We estimate that the proportion of investigations closed without a sanction or a warning will continue to rise.

Sections 10–12 bring together data from 2010–13 to examine patterns in fitness to practise cases.

- **Section 10:** The source of complaints (page 66)
- **Section 11:** Types of allegation (page 69)
- **Section 12:** Outcomes for different cohorts of doctors (page 72)

Key facts

- A low proportion of complaints from patients leads to a serious outcome.
- During 2010–13, an average of just over 80* doctors were suspended or erased each year.
- Employers make proportionately more complaints about BME doctors and non-UK graduates.
- A high proportion of complaints about GPs are from the public.
- A higher proportion of complaints in Northern Ireland come from doctors as opposed to other sources.
- Cases involving the health of the doctor and those where there are allegations of criminality are more likely to be investigated and to lead to a sanction or a warning.
- Cases involving substance misuse have the highest proportion of sanctions and warnings issued.
- Cases involving inappropriate sexual behaviour are the most likely to lead to erasure or suspension.
- Female GPs over 50 years old are twice as likely to receive a sanction or a warning than if they are aged 30–50 years.
- Doctors in England are more complained about than those in other parts of the UK.
- Doctors in the southwest of England have the lowest chance of being given a sanction or a warning.
- Among UK graduates, male doctors are more likely to be complained about and investigated if they are BME.
- BME female doctors are more complained about than white female doctors.
- Non-UK graduate GPs are more likely to be complained about and receive a sanction or a warning.
- Some specialties are more complained about and have a higher proportion of sanctions and warnings.
- Of those on the Specialist Register, male doctors receive more sanctions and warnings than female doctors.
- The older a doctor is when joining the register, the greater probability there is of them receiving a sanction or a warning.
- Male non-UK graduates joining the register aged 40–50 years have a much higher chance of being given a sanction or a warning.

Section 13 (page 84) shows how many complainants made multiple complaints about the same doctor during 2010–13 and, conversely, what proportion of doctors were complained about more than once.

Key facts

- Only one in 450 complainants made three or more complaints about the same doctor during 2010–13.
- Of doctors who were complained about, only 4.4% were complained about three or more times during 2010–13.

* At the time of analysis 1,289 cases that originated in 2013 were still under investigation and not counted here. When these case are investigated this number will be higher.

BOX 1: Our data across different parts of the UK

We have been able to locate 93% of doctors on ther medical register to one of the four countries of the UK or to a region within England. For revalidation, the vast majority of doctors are now connected to an organisation (usually their main employer), known as a designated body, and this is the most reliable way we can categorise their location. Where a doctor has no connection to a designated body or where the designated body is not geographically specific we have used employment addresses. For the doctors for whom we have neither, we have used the latest correspondence address.

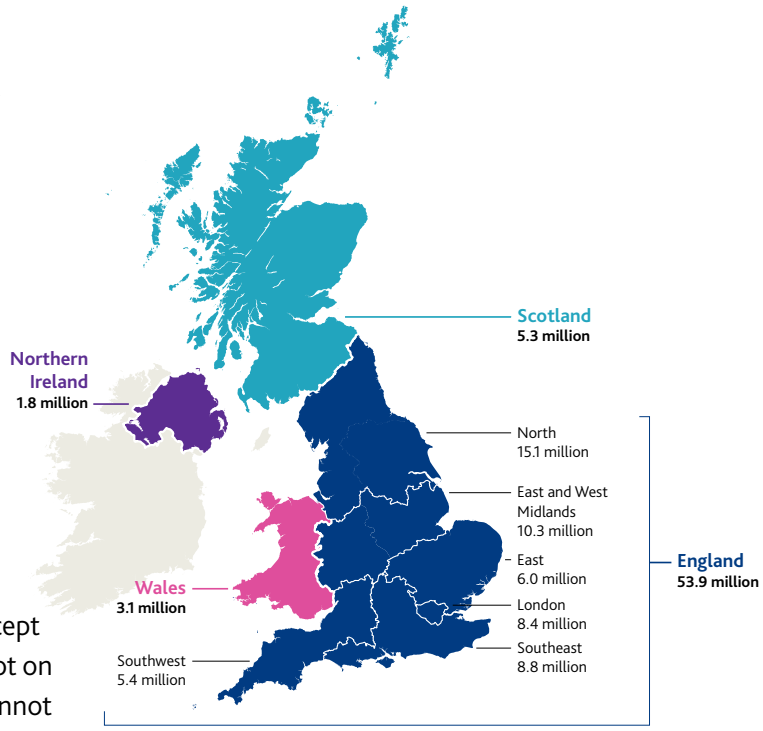
The countries and regions where we have located doctors are shown on the map opposite, together with the population that doctors are serving in each region. The regions in England are the NHS area teams with two of them split along clinical commissioning group boundaries.

The total number of doctors shown for countries and regions is a slight underestimate as the table below shows that it has not been possible to locate some doctors. Where we have maps and tables with a country and regional breakdown, the underestimate is shown.

The underestimate is generally less than 10%, except for doctors who are not in training and who are not on the GP or Specialist Register, among whom we cannot accurately locate 19%.

Of those we cannot locate 85% have overseas addresses. About a third of doctors we cannot locate are over 50 years old.

In most maps we show an index for a country or region relative to the UK average. The same colour scale is used for most maps, and the index rather than the colour should be used as a guide. If a map contains mostly lighter colours, the difference across the UK is not great. Darker colours signify greater differences.



DOCTORS WE CANNOT LOCATE	All licensed doctors	Doctors in training	Doctors not in training				Place of primary medical qualification		
			<30 years	30+ years			UK graduates	EEA graduates	IMGs
				GPs	Specialists	Neither			
% of doctors	6.8%	0.0004%	13%	2.3%	8.1%	19%	1.8%	29%	11%
Number of doctors*	16,092	7	1,023	1,346	5,782	7,818	2,766	6,840	6,486

* The numbers do not tally up because we could not locate a small number of doctors who were on both the GP and the Specialist Registers (116 doctors).

Section 1: The medical register and licensed doctors

The number of doctors on the UK medical register increased by 8.5% over three years to 259,650 in 2013 (figure 3). In 2013, female doctors made up 44% of all registered doctors, and 63% of doctors gained their primary medical qualification in the UK.

FIGURE 3: Changes in the demographic characteristics of doctors on the UK medical register between 2010 and 2013*

		2010			2013		
		Number of doctors	% total	% change	Number of doctors	% total	
TOTAL		**239,245**	**100%**	**8.5%**	**259,650**	**100%**	
GENDER							
All doctors	Male	139,324	58%	4.7%	145,877	56%	
	Female	99,921	42%	14%	113,773	44%	Female doctors made up 44% of doctors in 2013, up from 42% in 2010. We have seen a bigger increase in the population of female doctors than in that of male doctors.
AGE AND GENDER							
<30 years	**All**	**34,187**	**14%**	**11%**	**38,038**	**15%**	
	Male	13,286	5.6%	15%	15,236	5.9%	
	Female	20,901	8.7%	9.1%	22,802	8.8%	Growth of the population of female doctors relative to male doctors is slowing: the slowest growth was among female doctors under 30 years.
30–50 years	**All**	**141,721**	**59%**	**6.6%**	**151,131**	**58%**	
	Male	79,683	33%	1.0%	80,498	31%	
	Female	62,038	26%	14%	70,633	27%	Among groups aged 30 years and over, the growth in the population of male doctors was considerably slower than for female doctors, especially for doctors aged 30–50 years (1% versus 14%).
>50 years	**All**	**63,337**	**26%**	**11%**	**70,481**	**27%**	
	Male	46,355	19%	8.2%	50,143	19%	
	Female	16,982	7.1%	20%	20,338	7.8%	The most rapid increase in the population of female doctors was among those over 50 years old, with a 20% increase.

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

		2010			2013	
		Number of doctors	% total	% change	Number of doctors	% total
ETHNICITY						
BME	**All**	**66,044**	**28%**	**13%**	**74,917**	**29%**
	Asian	50,519	21%	12%	56,434	22%
	Black	6,571	2.7%	19%	7,841	3.0%
	Mixed	3,653	1.5%	24%	4,536	1.7%
	Other	5,301	2.2%	15%	6,106	2.4%
White		121,238	51%	11%	134,217	52%
Unknown		51,963	22%	-2.8%	50,516	19%
PLACE OF PRIMARY MEDICAL QUALIFICATION AND ETHNICITY						
UK graduates	**All**	**150,464**	**63%**	**9.5%**	**164,692**	**63%**
	BME	22,904	9.6%	25%	28,674	11%
	White	99,599	42%	8.4%	107,944	42%
	Unknown	27,961	12%	0.4%	28,074	11%
EEA graduates	**All**	**22,757**	**9.5%**	**19%**	**27,114**	**10%**
	BME	1,808	0.8%	32%	2,383	0.9%
	White	14,801	6.2%	29%	19,099	7.4%
	Unknown	6,148	2.6%	-8.4%	5,632	2.2%
IMGs	**All**	**66,024**	**28%**	**2.8%**	**67,844**	**26%**
	BME	41,332	17%	6.1%	43,860	17%
	White	6,838	2.9%	4.9%	7,174	2.8%
	Unknown	17,854	7.5%	-5.8%	16,810	6.5%

The proportions of BME and white doctors have remained broadly constant. But the populations of BME and white doctors have both grown, with the biggest increase for doctors of mixed and black ethnicity.

In 2013, we knew 81% of all doctors' ethnicity. We did not know the ethnicity of one in six UK graduates and one in four non-UK graduates. But recent reearch suggests that, despite these missing data, our broad conclusions related to ethnicity are fairly reliable (box 2, page 42).

Among UK graduates, the population of BME doctors has had the biggest growth.

The population of EEA graduates has grown by far more than that of UK graduates and IMGs. Despite this, EEA graduates were still only a tenth of all doctors in 2013, whereas IMGs represented a quarter.

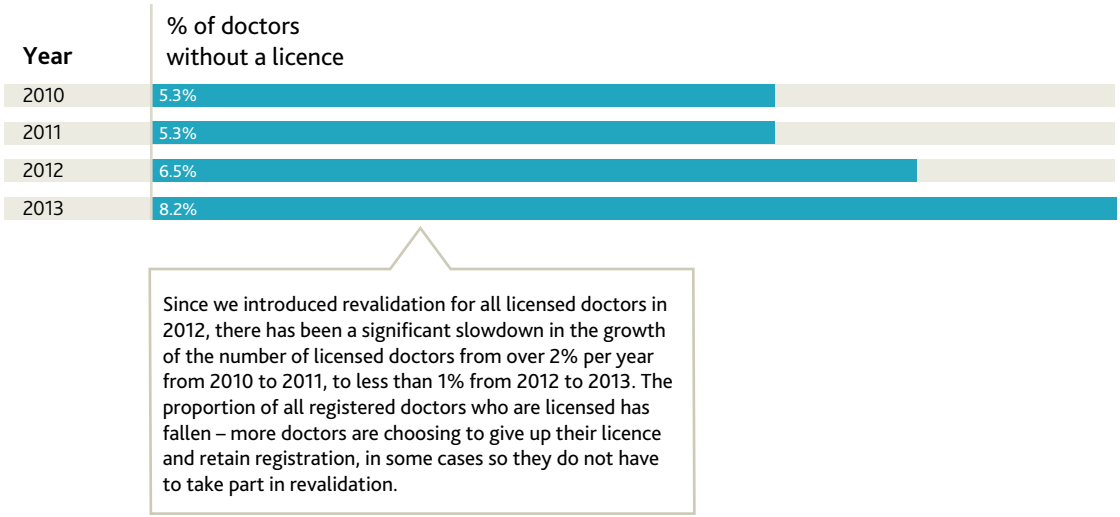
Registered doctors who are licensed to practise in the UK

Not all doctors on the medical register are licensed to practise medicine in the UK (figure 4). By staying on the register they are demonstrating that they remain in good standing with the GMC and that they want to retain a connection to the GMC and to the profession as a whole. They cannot treat patients but may be using their background and skills in a variety of different settings. The rest of the data in this year's report are for licensed doctors only, unless otherwise stated.

95% of doctors on the GP Register had a licence, closely followed by 92% on the Specialist Register and 90% of those not on either register.

Webappendix page 2 shows the demographic characteristics of doctors who do not have a licence and are therefore not included in the most of the report.

FIGURE 4: **The proportion of doctors on the medical register without a licence (2010–13)**



Section 2: Licensed doctors

Number of specialists growing faster than other doctors

There were 238,247 licensed doctors in the UK in 2013 (table 1), equivalent to 372 per 100,000 people. One in three were specialists, one in four were GPs, and one in five were not on the GP or Specialist Register or in training. The remainder were part of a postgraduate training programme.

Over the years between 2010 and 2013, the population of specialists increased by 12% and GPs by only 4%. The pressures on GPs have been widely reported over the past year and we discuss some of the issues arising in chapter 4.

TABLE 1: **Number of licensed doctors in the UK in 2010, 2012 and 2013**

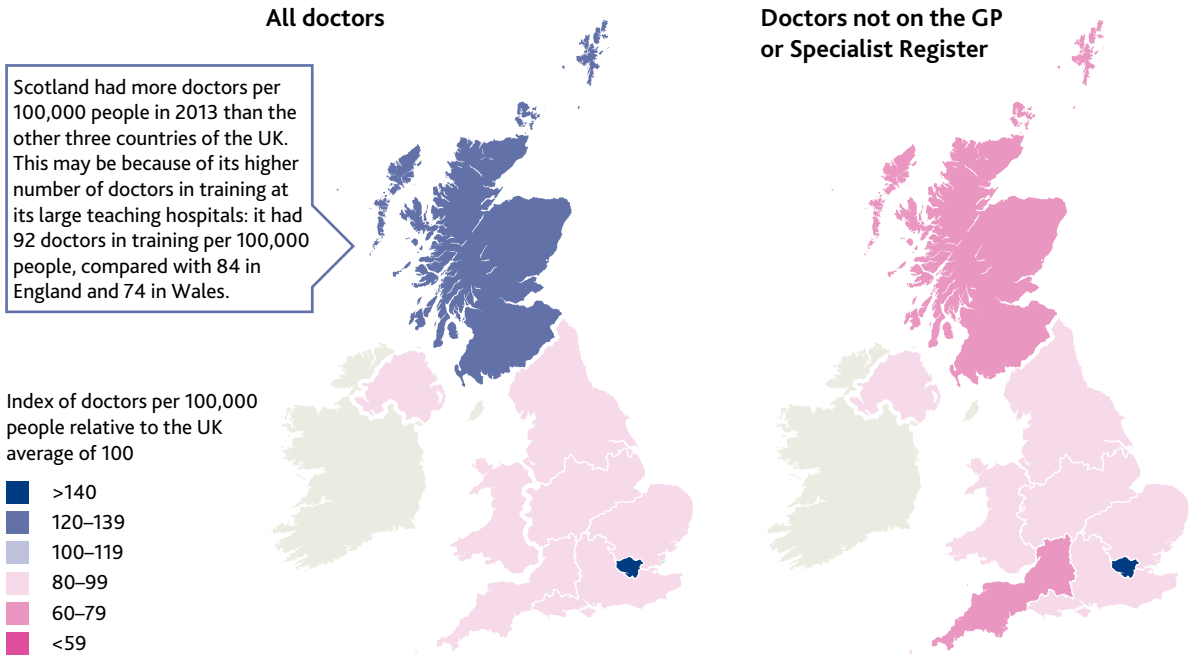
	All doctors	GPs	Specialists	Doctors not on the GP or Specialist Register		
				Including doctors in training	Excluding doctors in training	Only doctors in training
2013	238,247	58,996	71,461	106,496	48,027	58,469
2012	236,226	58,650	69,268	107,009	47,492	59,517
2010	226,660	56,892	63,604	104,925	n/a	n/a
1-year change (2012–13)	0.9%	0.6%	3.2%	-0.5%	1.1%	-1.8%
3-year change (2010–13)	5.1%	3.7%	12%	1.5%	n/a	n/a

Where do licensed doctors work?

We can locate about 90% of doctors (box 1, page 23). We have to exclude doctors who we cannot reliably assign to a particular part of the UK, leaving a baseline of 347 doctors per 100,000 people to analyse differences across parts of the UK (figure 5).

FIGURE 5: **Where licensed doctors were employed across the UK in 2013***

PART OF THE UK	All doctors: Number of doctors†	All doctors: Number of doctors per 100,000 people (500)	Doctors not on the GP or Specialist Register: Number of doctors‡	Doctors not on the GP or Specialist Register: Number of doctors per 100,000 people (130)
North	51,092	339	7,918	53
East and West Midlands	30,043	292	5,154	50
East	18,214	306	3,415	57
London	41,388	492	10,026	119
Southeast	30,161	343	5,112	58
Southwest	15,078	280	2,223	41
England (total)	185,976	345	33,848	63
Northern Ireland	6,319	345	962	53
Scotland	19,882	373	2,521	47
Wales	9,978	324	1,860	60
UK	222,155	347	39,191	61
UK (including doctors with unknown location)	238,247	372	48,027	75



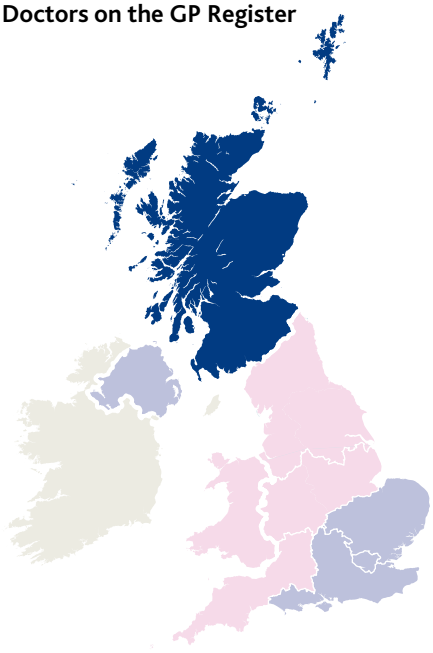
* Excludes doctors with unknown location unless otherwise specified, so the data probably underestimate the true numbers by about 6.8% for all doctors, 18% for doctors not on the GP or Specialist Register, 2.3% for GPs and 8.1% for specialists, some of whom had non-UK addresses.

† Includes doctors on both the GP and the Specialist Registers.

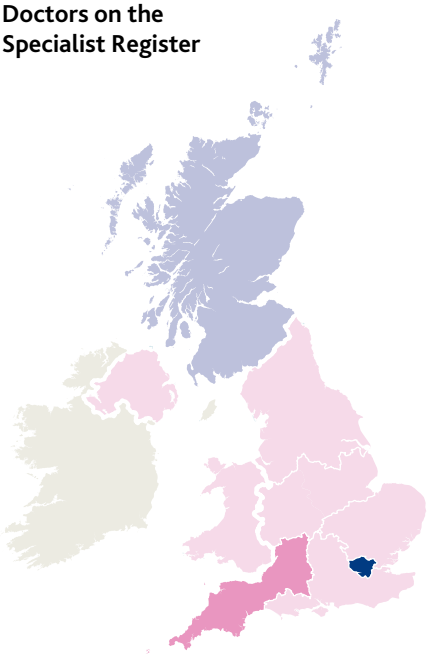
‡ Excludes doctors in training.

PART OF THE UK	Doctors on the GP Register: Number of doctors§	Doctors on the GP Register: Number of doctors per 100,000 people (120)	Doctors on the Specialist Register: Number of doctors§	Doctors on the Specialist Register: Number of doctors per 100,000 people (160)
North	13,175	88	15,268	101
East and West Midlands	7,690	75	8,734	85
East	5,566	93	5,480	92
London	7,822	93	12,743	151
Southeast	8,452	96	8,495	97
Southwest	4,733	88	4,304	80
England (total)	47,438	88	55,024	102
Northern Ireland	1,743	95	1,836	100
Scotland	5,848	110	5,858	110
Wales	2,617	85	2,960	96
UK	57,646	90	65,678	102
UK (including doctors with unknown location)	58,996	92	71,461	111

Doctors on the GP Register



Doctors on the Specialist Register



§ Excludes 1,294 doctors who were on both the GP and the Specialist Registers.

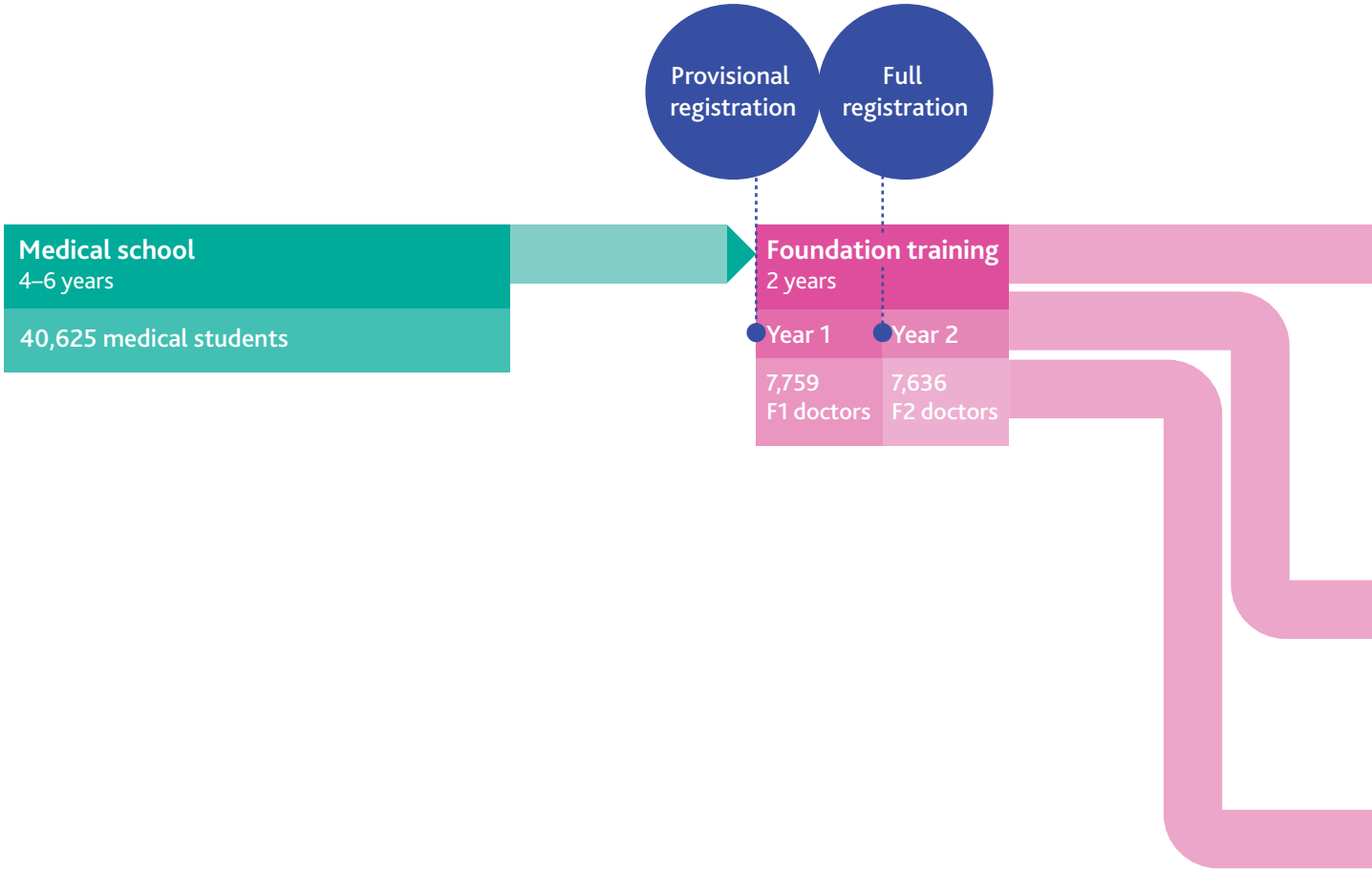
Section 3: Medical education and training

Training a doctor takes several years and involves many stages

This section includes data on both medical students and doctors in training. Figure 6 sets out the different stages of medical education and training.

When they graduate from medical school, all doctors working in the UK do two years of foundation training. They have to be provisionally registered with us before starting their first year of foundation training (F1). At the end of F1, doctors have to be fully registered before they can start the second year of foundation training (F2).

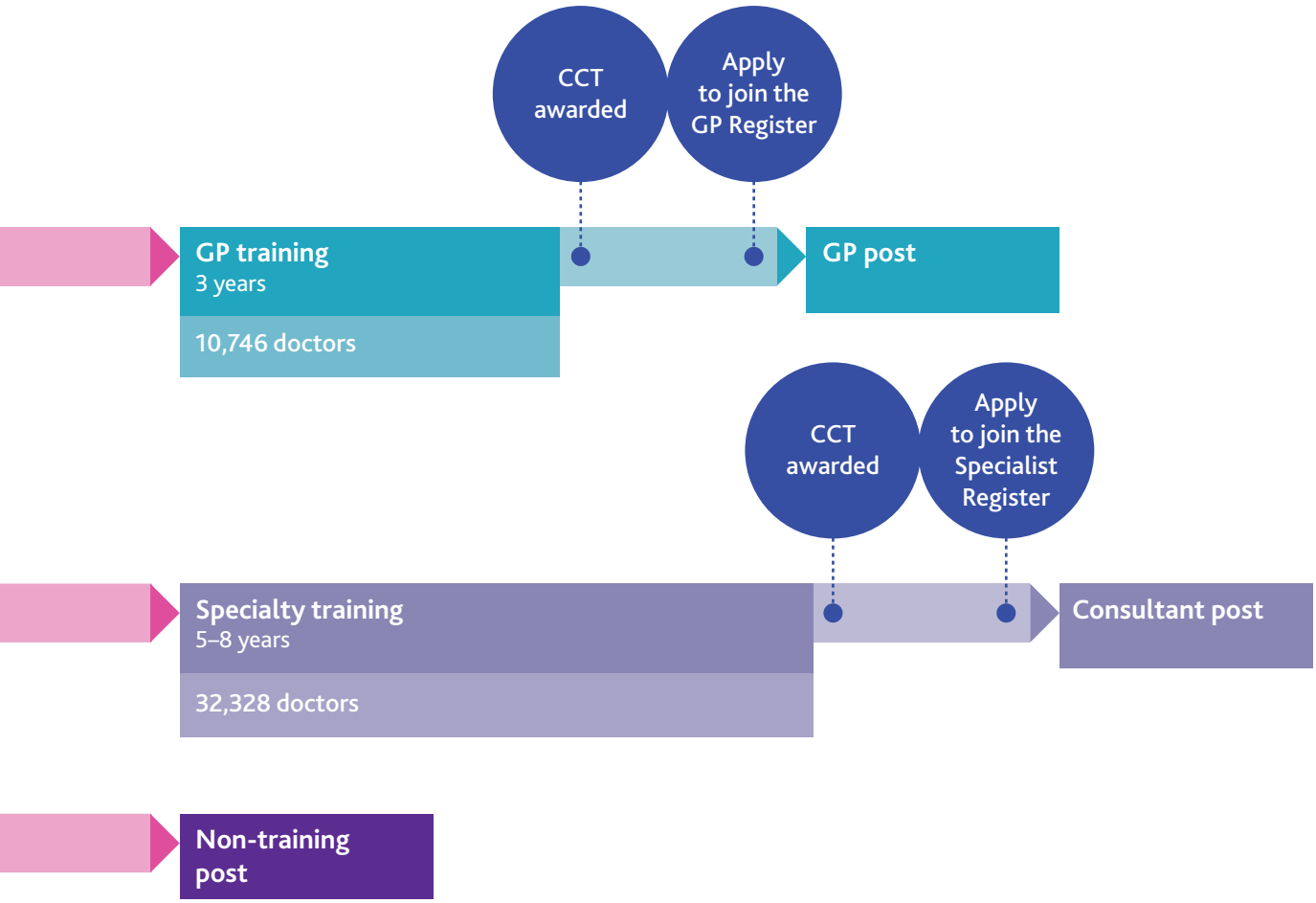
FIGURE 6: **How medical students and doctors progress through medical education and training***



* Numbers are for medical students and doctors at each stage of training in 2013.

As shown in figure 6, there are several routes that a doctor can follow after foundation training. Once a doctor successfully completes GP or specialty training, they will be awarded the Certificate of Completion of Training (CCT) and can apply to join the GMC's GP or Specialist Register.

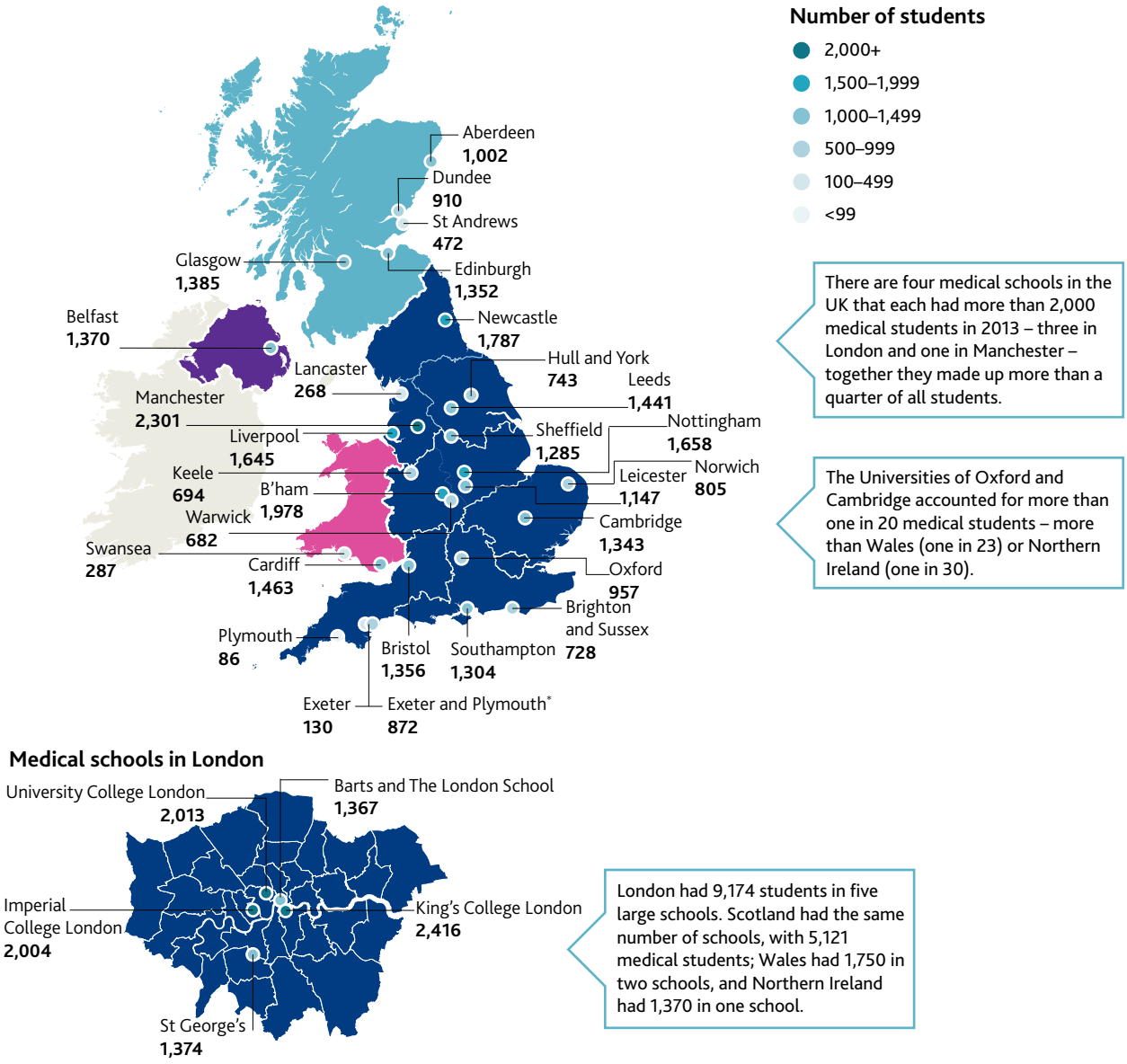
All doctors in training are required to take part in our annual national training survey. And much of the data on postgraduate medical education in this report comes from the survey.



Medical students

In 2013, there were 40,625 medical students in the UK. Figure 7 shows where these students were studying – notably there were more medical students in London than in Northern Ireland, Scotland and Wales combined.

FIGURE 7: Locations of medical schools in the UK



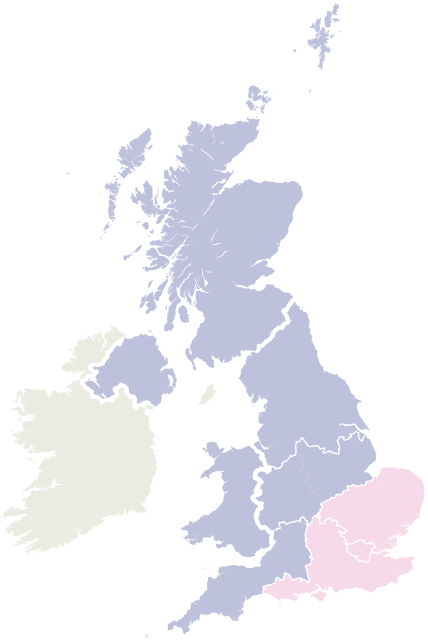
* In 2000, the Universities of Exeter and Plymouth founded a joint medical school – Peninsula College of Medicine and Dentistry. In 2013, this medical school separated into two – University of Exeter Medical School and Plymouth University Peninsula Schools of Medicine and Dentistry – and the two universities accepted their first cohorts of medical students studying for a degree at only one of the universities.

Growth in the population of female medical students is slowing

More than half of medical students were female in 2013, but the trend in recent years for an increasing number of female doctors may be diminishing (figure 8).

The drop in the number of medical students since 2012 was more marked for women (2.5%) than for men (1.3%).

FIGURE 8: **Where male and female medical students were studying across the UK in 2013**



Index of proportion of female medical students relative to the UK average of 100

- >140
- 120–139
- 100–119
- 80–99
- 60–79
- <59

PART OF THE UK	Number of medical students	% of medical students	
		Male	Female
North	9,470	46%	54%
East and West Midlands	6,159	42%	58%
East	2,148	48%	52%
London	9,174	49%	51%
Southeast	2,989	47%	53%
Southwest	2,444	44%	56%
England (total)	**32,384**	**46%**	**54%**
Northern Ireland	**1,370**	**43%**	**57%**
Scotland	**5,121**	**44%**	**56%**
Wales	**1,750**	**40%**	**60%**
UK	**40,625**	46%	54%

	All medical students	Male	Female
1-year change (2012–13)	-1.9%	-1.3%	-2.5%
3-year change (2010–13)	7.2%	11%	3.8%

Over 40% of BME medical students in the UK are of south Asian ethnicity

Where we know ethnicity, nearly two-thirds of medical students described themselves as white (figure 9). South Asians – people whose families have origins in India, Pakistan and Bangladesh – accounted for nearly half of BME medical students in England, around a third in Wales and in Northern Ireland, and a quarter in Scotland. Female medical students were the majority from all ethnic groups apart from south Asian (webappendix page 3).

FIGURE 9: Where medical students of different ethnicity were studying across the UK in 2013

ETHNICITY	UK		England		Northern Ireland	
	Number of medical students	% of medical students	Number of medical students	% of medical students	Number of medical students	% of medical students
White	25,649	66%	19,342	63%	1,152	85%
BME	13,116	34%	11,513	37%	207	15%
South Asian	5,578	14%	5,154	17%	39	2.9%
Other Asian (excluding Chinese)	1,875	4.8%	1,583	5.1%	62	4.6%
Chinese	1,772	4.6%	1,384	4.5%	63	4.6%
Black African*	947	2.4%	885	2.9%	14	1.0%
Mixed	1,652	4.3%	1,425	4.6%	14	1.0%
Other and other black	1,292	3.3%	1,082	3.5%	15	1.1%
Total†	**38,765**	**100%**	**30,855**	**100%**	**1,359**	**100%**

ETHNICITY	Scotland		Wales	
	Number of medical students	% of medical students	Number of medical students	% of medical students
White	3,787	78%	1,368	80%
BME	1,057	22%	339	20%
South Asian	257	5.3%	128	7.5%
Other Asian (excluding Chinese)	214	4.4%	16	0.9%
Chinese	289	6.0%	36	2.1%
Black African*	32	0.7%	16	0.9%
Mixed	156	3.2%	57	3.3%
Other and other black	109	2.3%	86	5.0%
Total†	**4,844**	**100%**	**1,707**	**100%**

As a proportion of all BME medical students, there were more Chinese students in Northern Ireland (30%) and Scotland (27%) than in England (12%) and Wales (11%).

Only one in 40 medical students identified as black African; this group had a particularly high proportion of female medical students (63%; webappendix page 3).

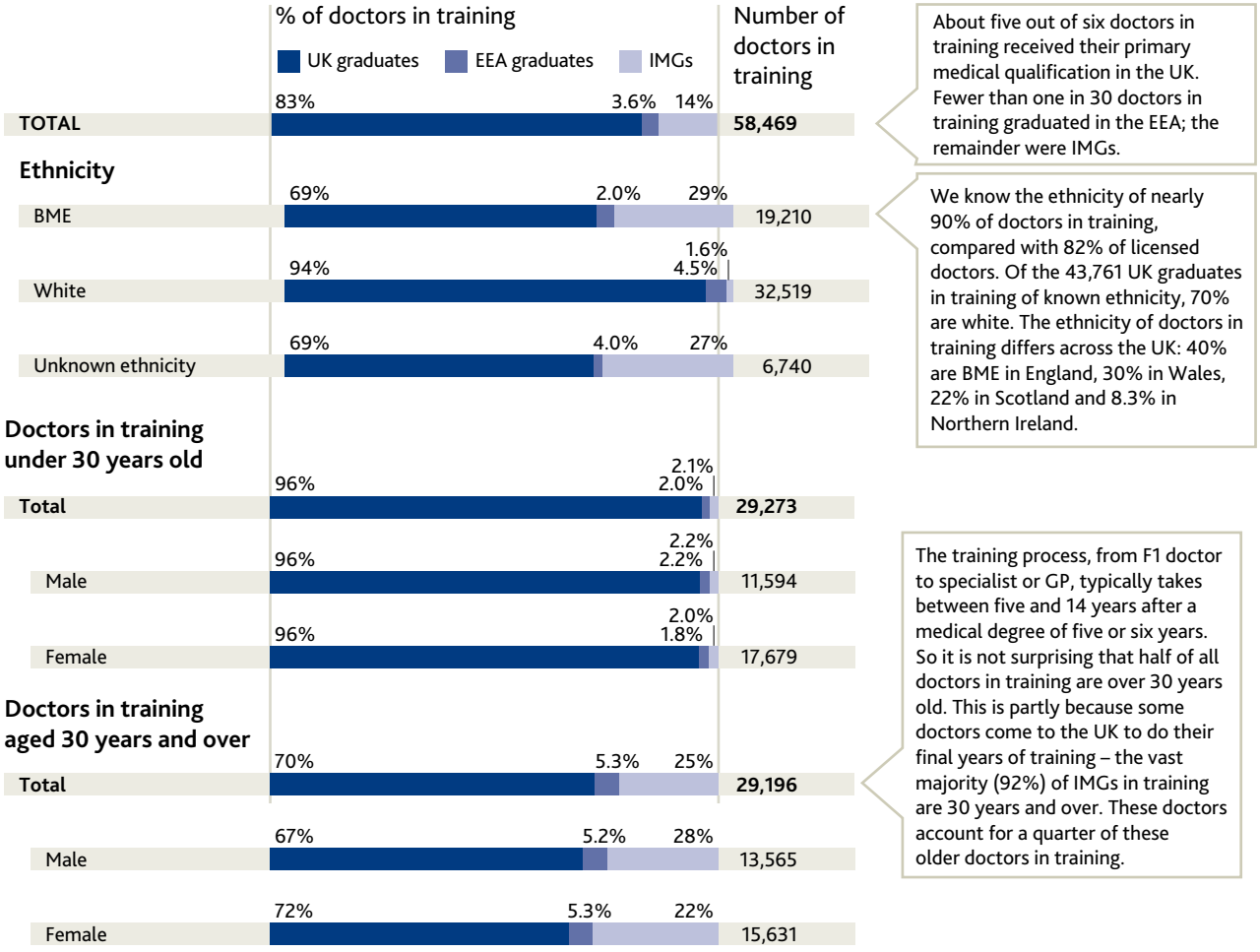
* This group accounts for 83% of the 1,072 medical students who identify as black.

† Excludes 1,860 medical students who did not supply their ethnicity: 1,529 in England, 11 in Northern Ireland, 277 in Scotland and 43 in Wales.

Nearly 60,000 doctors are in training

The number of doctors in training fell by nearly 2% from 59,535 in 2012 to 58,469 in 2013. Figure 10 shows where these doctors gained their primary medical qualification.

FIGURE 10: **Where doctors in training gained their primary medical qualification (2013)**



About five out of six doctors in training received their primary medical qualification in the UK. Fewer than one in 30 doctors in training graduated in the EEA; the remainder were IMGs.

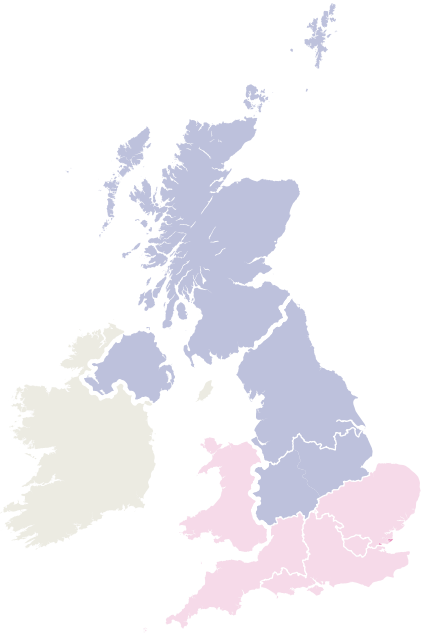
We know the ethnicity of nearly 90% of doctors in training, compared with 82% of licensed doctors. Of the 43,761 UK graduates in training of known ethnicity, 70% are white. The ethnicity of doctors in training differs across the UK: 40% are BME in England, 30% in Wales, 22% in Scotland and 8.3% in Northern Ireland.

The training process, from F1 doctor to specialist or GP, typically takes between five and 14 years after a medical degree of five or six years. So it is not surprising that half of all doctors in training are over 30 years old. This is partly because some doctors come to the UK to do their final years of training – the vast majority (92%) of IMGs in training are 30 years and over. These doctors account for a quarter of these older doctors in training.

Doctors in training are an important part of the medical workforce

A quarter of all doctors in the UK are in training. Figure 11 shows that certain parts of the country rely on doctors in training more than others do.

FIGURE 11: Where doctors in training were working across the UK in 2013



Index of doctors in training relative to the UK average of 100

- >140
- 120–139
- 100–119
- 80–99
- 60–79
- <59

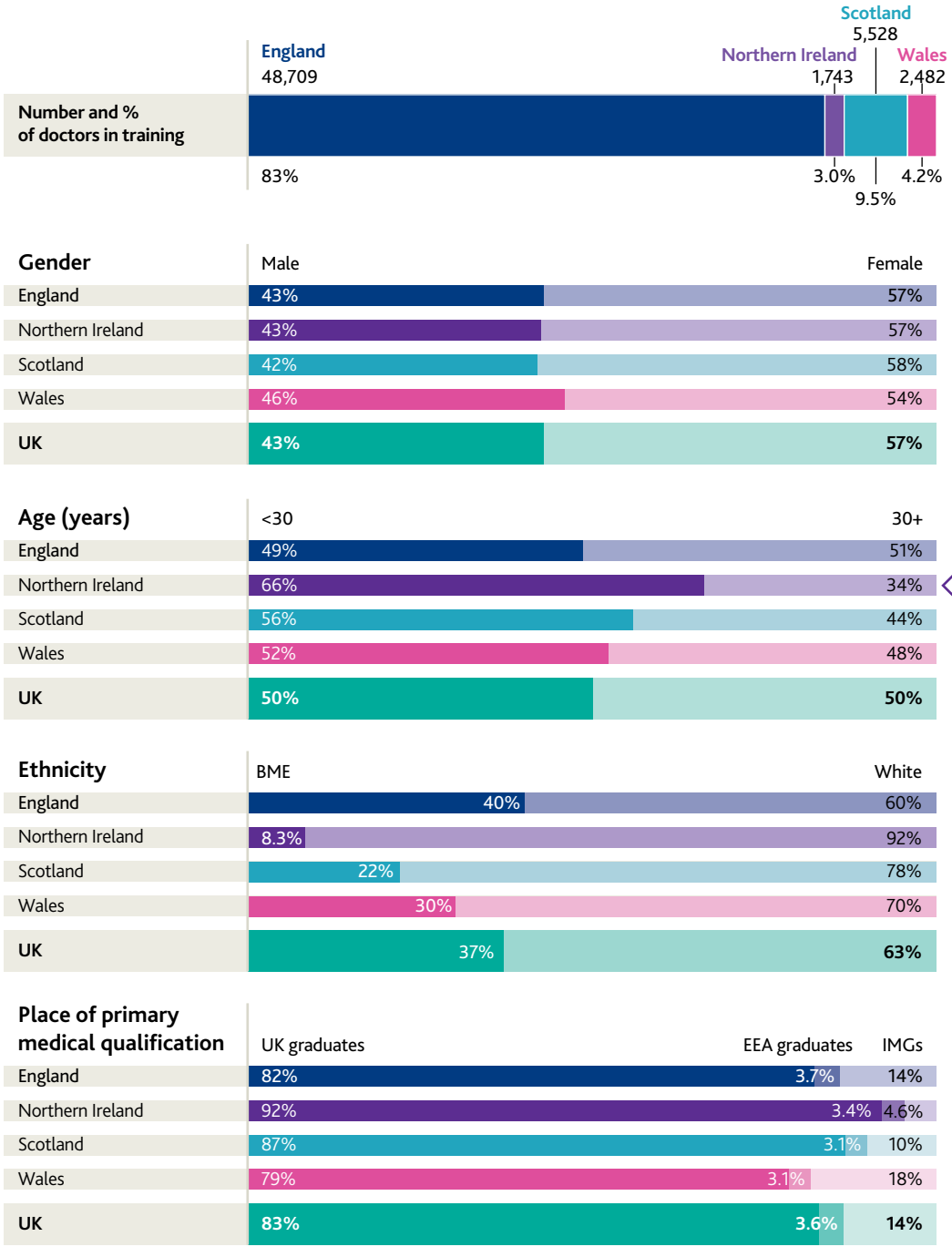
PART OF THE UK	Number of all doctors*	% of doctors in training (30% scale)
North	51,092	28%
East and West Midlands	30,043	28%
East	18,214	20%
London	41,338	26%
Southeast	30,161	26%
Southwest	15,078	25%
England (total)	**185,976**	26%
Northern Ireland	**6,319**	28%
Scotland	**19,882**	28%
Wales	**9,978**	25%
UK	**222,155**	26%
UK (including doctors with unknown location)	**238,247**	25%

The proportion of doctors who were in training ranged from 20% in the east of England to 26% in London and 28% in the north of England.

* Excludes doctors with unknown location unless otherwise specified, so the data excludes 6.8% of doctors, some of whom had non-UK addresses.

Who are doctors in training?

FIGURE 12: **Demographic characteristics of doctors in training across the UK in 2013***

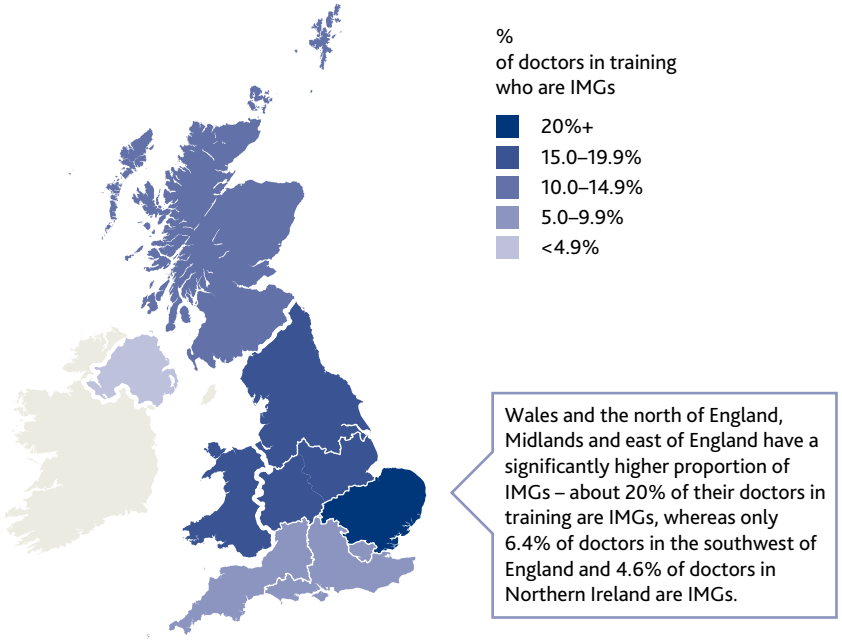


Doctors in training in Northern Ireland are markedly younger than in other countries in the UK. This is probably partly because Northern Ireland has a lower proportion of IMGs in training.

* Excludes doctors with unknown location.

IMGs in training are less prevalent in the southwest of England and Northern Ireland

FIGURE 13: **Where IMGs in training were working across the UK in 2013**



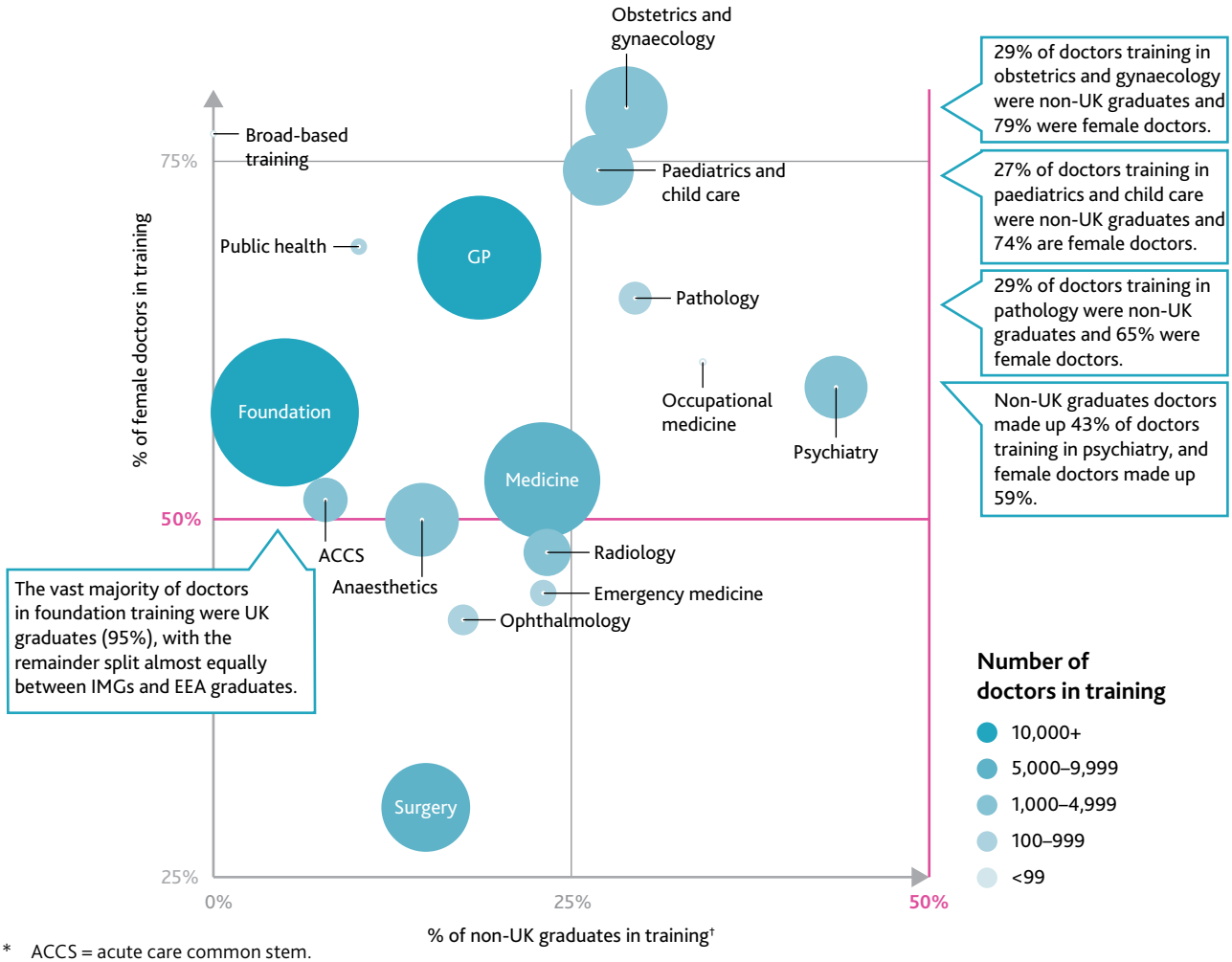
More than a third of psychiatrists in training are non-UK graduates

Most specialties are relatively evenly split by gender but, for certain career paths, there are substantial and known differences. For example, a far higher proportion of male doctors train in surgery, and a higher proportion of female doctors opt for general practice, obstetrics and gynaecology, and paediatrics.

Figure 14 shows the correlation between the specialties that non-UK graduates and female doctors choose (see webappendix page 7 for the number of doctors and the percentages of female doctors, and page 9 for non-UK graduates).

EEA graduates form a smaller proportion of doctors in specialty training, ranging from 2–5% in most cases, but they form a slightly higher proportion of doctors in psychiatry and pathology training (both 8%).

FIGURE 14: Gender and place of primary medical qualification of doctors training in specialties across the UK in 2013



* ACCS = acute care common stem.

† Includes EEA graduates and IMGs.

Section 4: Doctors under 30 years old who are not in training

An increasing number of young doctors are not in training

There were nearly 8,000 licensed doctors under 30 years old who were not in training in 2013 (figure 15). The number of these doctors increased by about 10% during 2012–13, while the number in training declined by about 2%. Figure 16 shows where these doctors are working across the UK.

A small number of these doctors (870) have already qualified as GPs, while the others are doing a variety of roles.

FIGURE 15: **Changes in the gender of doctors on the UK medical register, who were under 30 years old and not in training, between 2012 and 2013**

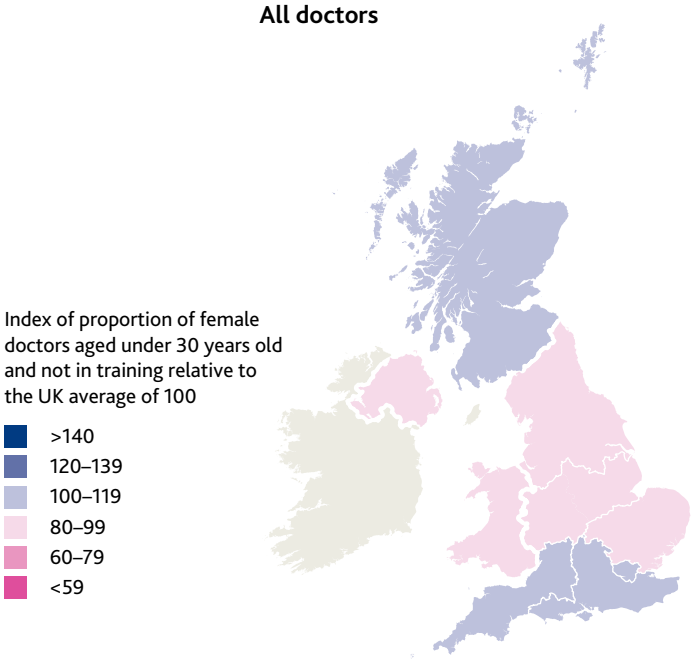
	2012		% change	2013	
	Number of doctors	% total		Number of doctors	% total
TOTAL	**7,115**	**100%**	**9.8%**	**7,812**	**100%**
Male	2,969	42%	10%	3,268	42%
Female	4,146	58%	9.6%	4,544	58%

Nearly 60% of these doctors are female, which is similar to the proportion of female doctors in this age group who are in training (figure 12, page 37).

FIGURE 16: **Where licensed doctors, who were under 30 years old and not in training, were employed across the UK in 2013***

PART OF THE UK	Number of doctors	% of doctors	
		Male	Female
North	1,502	45%	55%
East and West Midlands	822	43%	57%
East	436	44%	56%
London	1,576	40%	60%
Southeast	823	40%	60%
Southwest	452	39%	61%
England (total)	5,611	42%	58%
Northern Ireland	279	42%	58%
Scotland	610	34%	66%
Wales	289	45%	55%
UK	6,789	41%	59%
UK (including doctors with unknown location)	**7,812**	**42%**	**58%**

Scotland had the highest proportion of female doctors who were not in training, whereas Wales and the North of England had the lowest.



* Excludes doctors with unknown location unless otherwise specified, so the data excludes 13% of doctors, some of whom had non-UK addresses.

Section 5: Doctors aged 30 years and over who are no longer in training

In 2013, there were just over 170,000 doctors aged 30 years and over who were no longer in training, either because they finished training or because they decided not to continue training (figure 17, page 43).

Two-fifths of these doctors were on the Specialist Register and about a third were on the GP Register. Almost a quarter were not on the GP or Specialist Register. They may be working in the NHS as specialty doctors – a non-training grade post for someone who has had at least four years of postgraduate training, two of those being in a relevant specialty, or equivalent training outside the UK.

They may have made an active choice not to train or to join a register, but some specialty doctors have had difficulty securing a training post or they have not passed their membership exams or assessments.[14]

The three figures on pages 44–49 map where these doctors were working across the UK in 2013, showing differences between male and female doctors (figure 18, page 44), place of primary medical qualification (figure 19, page 46) and between BME and white doctors (figure 20, page 48). The numbers of doctors in each group from each part of the UK are shown in webappendix pages 4–5.

BOX 2: Doctors with unknown ethnicity

In 2013, as part of our research for a recent report,[15] we did a survey of nearly 3,500 doctors that allowed us to gather information for doctors on the register whose ethnicity we did not know. 515 doctors with unknown ethnicity answered the question on ethnicity in this survey: 62% were white and 38% were BME. These proportions are extremely close to the proportions of white and BME doctors on our register, when we exclude doctors with unknown ethnicity – 63% and 37% respectively.

This means we are confident that excluding doctors with unknown ethnicity does not distort our comparisons between BME and white doctors, and our broad conclusions related to ethnicity are fairly reliable. But our findings should be treated with caution because we cannot control for all differences between doctors with known and unknown ethnicity.

FIGURE 17: Changes in the demographic characteristics of doctors on the UK medical register, who were aged 30 years and over and who were not in training, between 2012 and 2013

	2012			2013	
	Number of doctors	% total*	% change	Number of doctors	% total*
Total	**169,594**	**100%**	**1.4%**	**171,966**	**100%**
AGE AND GENDER					
30–50 years					
Male	61,208	56%	0.4%	61,466	55%
Female	48,558	44%	4.1%	50,525	45%
Total	**109,766**	**100%**	**2.0%**	**111,991**	**100%**
>50 years					
Male	43,197	72%	-0.9%	42,805	71%
Female	16,631	28%	3.2%	17,170	29%
Total	**59,828**	**100%**	**0.2%**	**59,975**	**100%**
PLACE OF PRIMARY MEDICAL QUALIFICATION					
UK graduates	99,014	58%	1.6%	100,620	59%
EEA graduates	19,973	12%	3.0%	20,567	12%
IMGs	50,607	30%	0.3%	50,779	30%
ETHNICITY					
BME	46,776	28%	4.6%	48,939	29%
White	86,543	51%	1.6%	87,958	51%
Unknown	36,275	21%	-3.3%	35,069	20%

* Percentages for the age and gender data are for each age group.

The proportion of female doctors is increasing, with a rise of nearly 2,000 female doctors aged 30–50 years during 2012–13, compared with only 258 male doctors. Female doctors made up almost half of doctors aged 30–50 years, compared with a little over a quarter of those aged over 50 years.

Of doctors aged 30 years and over, almost 60% of those not in training were UK graduates, compared with 83% of doctors in training (figure 10, page 35).

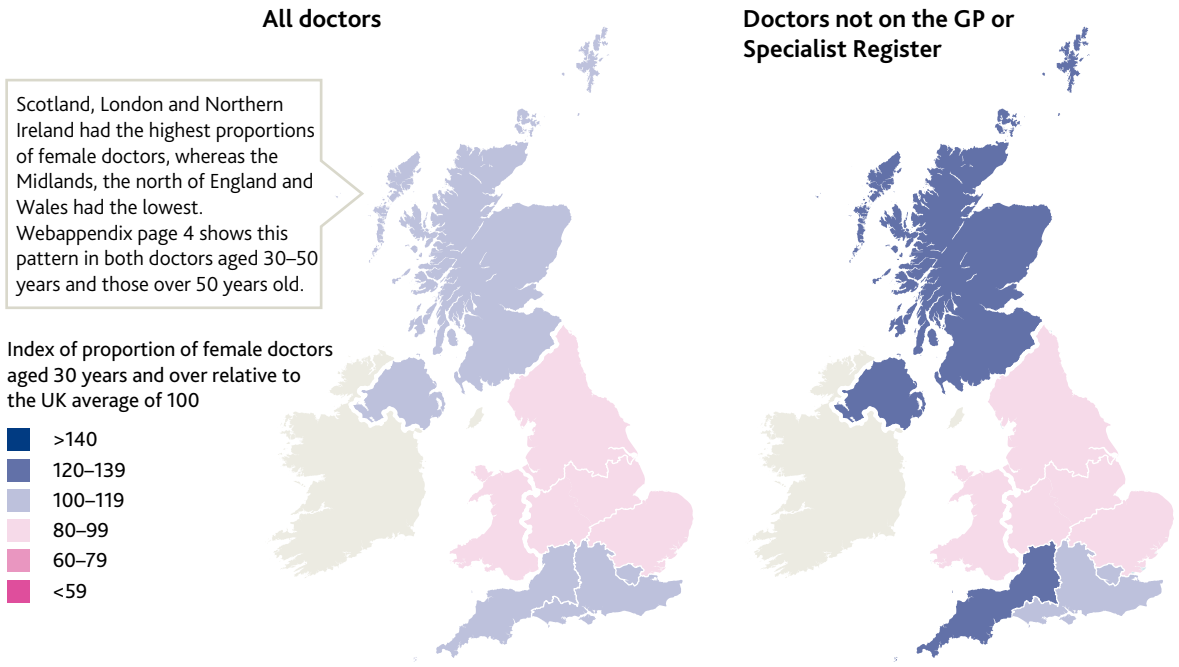
The supply of IMGs is slowing, increasing by only 0.3% – just 172 more doctors – which may be due to changes in visa requirements. The population of EEA graduates grew much faster than that of UK graduates, but accounted for fewer doctors (594 versus 1,606 doctors).

In 2013, we knew the ethnicity of nearly 80% of doctors aged 30 years and over who were not in training. Of these, 36% were BME. From the information we have about doctors with unknown ethnicity, we are confident that our conclusions about the ethnicity of doctors are reasonably robust (box 2, page 42).

Scotland, London and Northern Ireland have more female doctors aged 30 years and over than other parts of the UK

FIGURE 18: Where male and female doctors aged 30 years and over, and not in training, were employed across the UK in 2013*

PART OF THE UK	All doctors			Doctors not on the GP or Specialist Register		
	Number of doctors	% of doctors		Number of doctors	% of doctors	
		Male	Female		Male	Female
North	35,067	63%	37%	6,647	65%	35%
East and West Midlands	20,897	64%	36%	4,488	65%	35%
East	14,155	61%	39%	3,020	63%	37%
London	29,177	56%	44%	8,559	57%	43%
Southeast	21,449	58%	42%	4,382	59%	41%
Southwest	10,911	57%	43%	1,829	52%	48%
England (total)	131,656	60%	40%	28,925	60%	40%
Northern Ireland	4,297	57%	43%	726	47%	53%
Scotland	13,744	55%	45%	2,026	49%	51%
Wales	7,207	62%	38%	1,599	61%	39%
UK	156,904	60%	40%	33,276	59%	41%
UK (including doctors with unknown location)	171,966	61%	39%	41,094	61%	39%

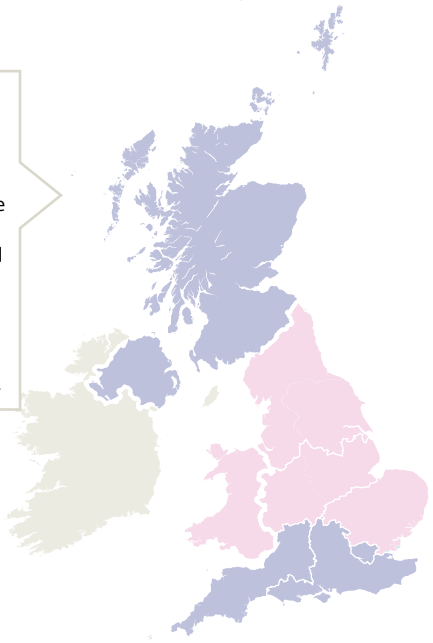


* Excludes doctors with unknown location unless otherwise specified, so data excludes 9% of all doctors, 19% of doctors not on the GP or Specialist Register, 2% of GPs and 8% of specialists, some of whom had non-UK addresses.

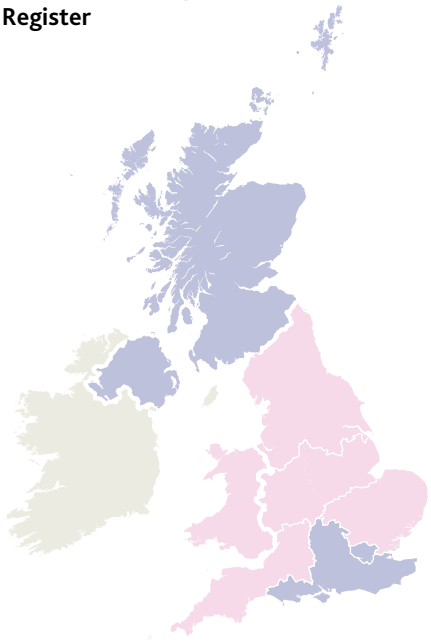
PART OF THE UK	Doctors on the GP Register			Doctors on the Specialist Register		
	Number of doctors	% of doctors		Number of doctors	% of doctors	
		Male	Female		Male	Female
North	12,944	53%	47%	15,268	70%	30%
East and West Midlands	7,536	56%	44%	8,732	71%	29%
East	5,525	53%	47%	5,480	69%	31%
London	7,716	47%	53%	12,740	62%	38%
Southeast	8,361	48%	52%	8,493	67%	33%
Southwest	4,676	49%	51%	4,303	68%	32%
England (total)	46,758	51%	49%	55,016	68%	32%
Northern Ireland	1,700	50%	50%	1,836	66%	34%
Scotland	5,733	46%	54%	5,858	65%	35%
Wales	2,589	52%	48%	2,960	70%	30%
UK	56,780	51%	49%	65,670	68%	32%
UK (including doctors with unknown location)†	58,126	51%	49%	71,452	68%	32%

Female doctors accounted for half of GPs and a third of specialists aged 30 years and over. Webappendix page 4 shows that this effect was more pronounced when separating out age groups: of doctors aged 30–50 years, 58% of GPs and 37% of specialists were female; of doctors who where over 50 years old, only 35% of GPs and 23% of specialists were female.

Doctors on the GP Register



Doctors on the Specialist Register



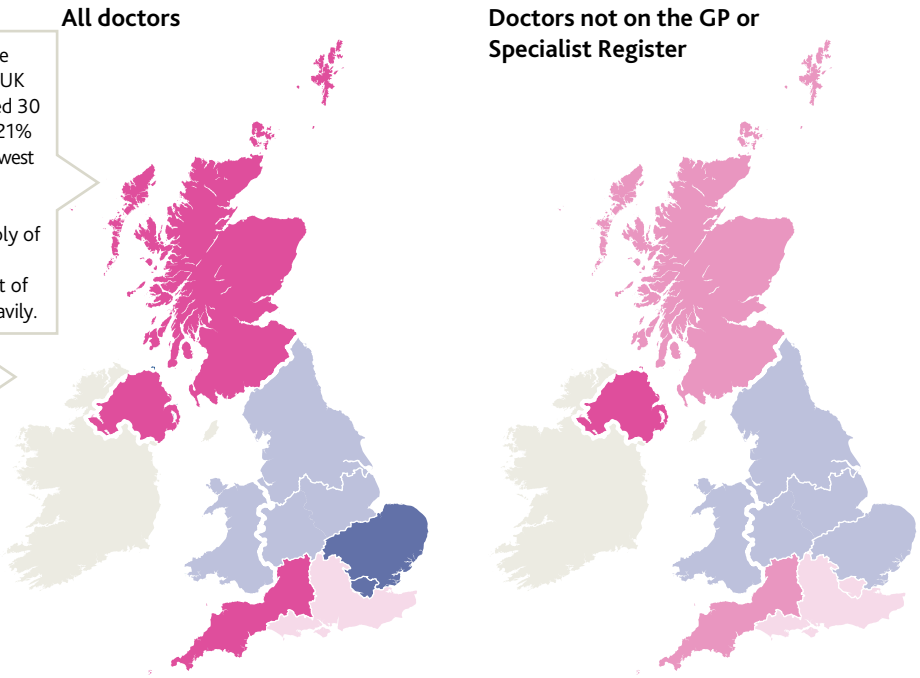
We rely more heavily on non-UK graduates as specialists than as GPs

FIGURE 19: Where UK graduates, EEA graduates and IMGs aged 30 years and over, and not in training, were employed across the UK in 2013*

PART OF THE UK	All doctors: Number of doctors	All doctors: % of doctors (UK graduates / EEA graduates / IMGs)	Doctors not on the GP or Specialist Register: Number of doctors	Doctors not on the GP or Specialist Register: % of doctors (UK graduates / EEA graduates / IMGs)
North	35,067	61% / 7% / 31%	6,647	27% / 9% / 64%
East and West Midlands	20,897	56% / 7% / 37%	4,488	23% / 9% / 68%
East	14,155	54% / 10% / 36%	3,020	23% / 11% / 66%
London	29,177	54% / 14% / 32%	8,559	33% / 16% / 52%
Southeast	21,449	66% / 9% / 25%	4,382	32.5% / 12% / 56%
Southwest	10,911	79% / 7% / 14%	1,829	51% / 10% / 40%
England (total)	131,656	60% / 9% / 30%	28,925	30% / 12% / 58%
Northern Ireland	4,297	79% / 13% / 8%	726	61% / 12% / 26%
Scotland	13,744	80% / 6% / 14%	2,026	53% / 8% / 39%
Wales	7,207	62% / 7% / 31%	1,599	28% / 7% / 65%
UK	156,904	62% / 9% / 28%	33,276	32% / 11% / 57%
UK (including doctors with unknown location)	171,966	59% / 12% / 30%	41,094	28% / 15% / 57%

Scotland, Northern Ireland and the southwest of England bucked the UK average for non-UK graduates aged 30 years and over. 20% in Scotland, 21% in Northern Ireland and 21% in southwest England were non-UK graduates. These areas are not likely to be so impacted by the reduction in supply of IMGs (figure 17, page 43), unlike London, the Midlands and the east of England that rely on them more heavily.

In Northern Ireland there was a particularly high proportion of EEA graduates (13% compared with 9% elsewhere). This is because 74% of EEA graduates in Northern Ireland graduated in Ireland. This means that in Northern Ireland 90% of doctors were graduates of either the UK or Ireland.



* Excludes doctors with unknown location unless otherwise specified, so the data excludes 8.8% of all doctors, 19% of doctors not on the GP or Specialist Register, 2.3% for GPs and 8.1% of specialists, some of whom had non-UK addresses.

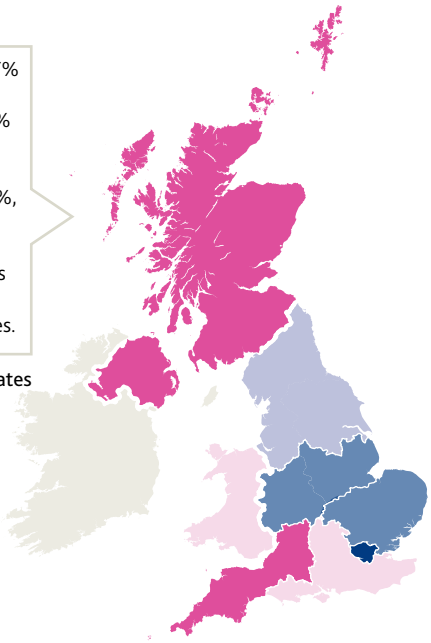
PART OF THE UK	Doctors on the GP Register: Number of doctors	% of doctors: UK graduates	EEA graduates	IMGs	Doctors on the Specialist Register: Number of doctors	% of doctors: UK graduates	EEA graduates	IMGs
North	12,944	76%	5%	19%	15,268	63%	9%	28%
East and West Midlands	7,536	73%	4%	23%	8,732	57%	10%	33%
East	5,525	70%	7%	24%	5,480	55%	12%	33%
London	7,716	66%	7%	26%	12,740	61%	17%	22%
Southeast	8,361	81%	5%	14%	8,493	68%	11%	21%
Southwest	4,676	91%	5%	5%	4,303	78%	9%	13%
England (total)	46,758	76%	5%	19%	55,016	63%	12%	26%
Northern Ireland	1,700	87%	12%	1%	1,836	78%	13%	8%
Scotland	5,733	91%	4%	5%	5,858	78%	8%	13%
Wales	2,589	80%	4%	15%	2,960	64%	10%	26%
UK	56,780	78%	5%	17%	65,670	64%	11%	24%
UK (including doctors with unknown location)†	58,126	77%	6%	17%	71,452	60%	15%	24%

77% of GPs were UK graduates and 17% were IMGs. By contrast, 64% of specialists were UK graduates and 24% were IMGs. But the supply of IMGs is slowing – in 2013, the increase in new IMGs aged 30 years and over was 0.3%, which again is likely to be caused by changes in visa requirements. By contrast, the number of EEA graduates increased by 3% (594 doctors), more than the 1.6% increase in UK graduates.

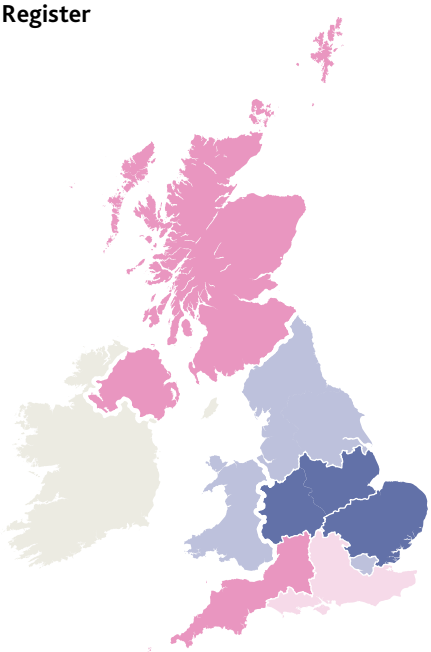
Index of proportion of non-UK graduates aged 30 years and over relative to the UK average of 100

- >140
- 120–139
- 100–119
- 80–99
- 60–79
- <59

Doctors on the GP Register



Doctors on the Specialist Register



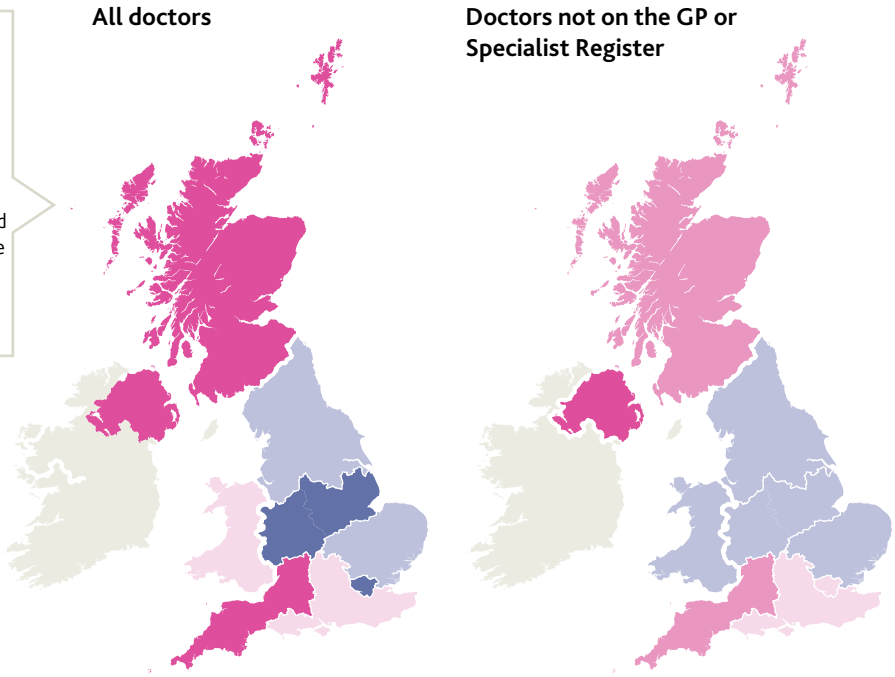
Doctors' ethnicity varies by part of the UK

FIGURE 20: Where doctors aged 30 years and over, and not in training, from different ethnic groups were employed across the UK in 2013*

PART OF THE UK	All doctors: Number of doctors	All doctors: % of doctors (BME / White / Unknown)	Doctors not on the GP or Specialist Register: Number of doctors	Doctors not on the GP or Specialist Register: % of doctors (BME / White / Unknown)
North	35,067	33% / 52% / 16%	6,647	54% / 27% / 19%
East and West Midlands	20,897	39% / 45% / 15%	4,488	57% / 24% / 20%
East	14,155	36% / 48% / 17%	3,020	53% / 26% / 21%
London	29,177	36% / 45% / 19%	8,559	45% / 33% / 22%
Southeast	21,449	25% / 56% / 19%	4,382	44% / 34% / 22%
Southwest	10,911	13% / 71% / 16%	1,829	30% / 51% / 19%
England (total)	131,656	32% / 51% / 17%	28,925	49% / 31% / 21%
Northern Ireland	4,297	8% / 63% / 29%	726	19% / 48% / 32%
Scotland	13,744	12% / 60% / 28%	2,026	28% / 43% / 29%
Wales	7,207	24% / 48% / 28%	1,599	45% / 25% / 30%
UK	156,904	29% / 52% / 19%	33,276	46% / 32% / 22%
UK (including doctors with unknown location)	171,966	28% / 51% / 20%	41,094	43% / 32% / 25%

There were large differences in the proportion of BME doctors aged 30 years and over across different parts of the UK. Among those whose ethnicity is known, the proportion was particularly low in Northern Ireland (11%), Scotland (17%) and the southwest of England (15%). By contrast, (38%) of doctors in England and (33%) of doctors in Wales were BME. The Midlands (47%) and London (44%) had particularly high proportions of BME doctors.

We know less about the ethnicity of doctors aged 30 years and over in Northern Ireland, Scotland and Wales. In 2013, we were missing ethnicity information for 17% of these doctors in England, which is a lower propotion than in Northern Ireland (29%), Scotland (28%) and Wales (28%).

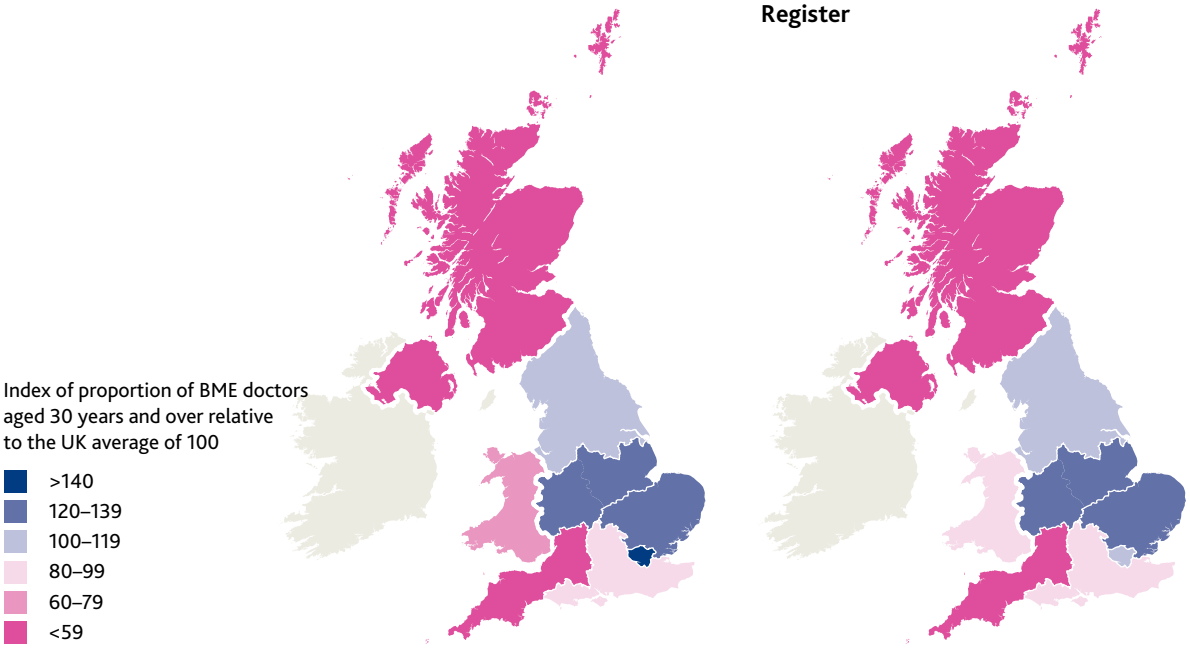


* Excludes doctors with unknown location unless otherwise specified, so the data excludes 8.8% of all doctors, 19% of doctors not on the GP or Specialist Register, 2.3% of GPs and 8.1% of specialists, some of whom had non-UK addresses.

PART OF THE UK	Doctors on the GP Register				Doctors on the Specialist Register			
	Number of doctors	% of doctors BME	% of doctors White	% of doctors Unknown	Number of doctors	% of doctors BME	% of doctors White	% of doctors Unknown
North	12,944	23%	55%	22%	15,268	32%	59%	9%
East and West Midlands	7,536	31%	48%	22%	8,732	38%	54%	8%
East	5,525	27%	50%	23%	5,480	35%	56%	9%
London	7,716	39%	35%	26%	12,740	29%	59%	12%
Southeast	8,361	17%	59%	23%	8,493	23%	63%	13%
Southwest	4,676	6%	73%	22%	4,303	13%	77%	9%
England (total)	46,758	25%	52%	23%	55,016	30%	60%	10%
Northern Ireland	1,700	2%	73%	25%	1,836	8%	59%	32%
Scotland	5,733	7%	67%	27%	5,858	12%	58%	30%
Wales	2,589	14%	58%	28%	2,960	21%	51%	28%
UK	56,780	22%	55%	24%	65,670	27%	60%	13%
UK (including doctors with unknown location)†	58,126	21%	55%	24%	71,452	26%	59%	15%

Doctors on the GP Register

Doctors on the Specialist Register



Section 6: Specialties

The number of doctors on the Specialist Register grew by 12% during 2010–13, driven by EEA graduates and IMGs

TABLE 2: **Demographic characteristics of doctors on the Specialist Register in 2013**

SPECIALTY GROUP	% of doctors Gender Male	Female	Age (years) < 50	> 50	Place of primary medical qualification UK graduates	EEA graduates	IMGs	Ethnicity BME	White
Medicine	68%	32%	65%	35%	66%	13%	20%	30%	70%
Surgery	90%	10%	61%	39%	58%	22%	20%	28%	72%
Anaesthetics and intensive care	68%	32%	68%	32%	62%	15%	23%	26%	74%
Psychiatry	59%	41%	60%	40%	59%	13%	32%	35%	65%
Radiology	65%	35%	66%	34%	67%	12%	22%	31%	69%
Paediatrics	50%	50%	65%	35%	54%	14%	32%	37%	63%
Obstetrics and gynaecology	54%	46%	60%	41%	44.%	16%	40%	44%	56%
Pathology	57%	43%	53%	47%	57%	14%	29%	31%	69%
Ophthalmology	74%	26%	62%	38%	51%	24.%	25%	34%	66%
Emergency medicine	70%	30%	76%	24%	73%	8%	19%	25%	75%
Public health	50%	50%	41%	59%	74%	8%	18%	26%	74%
Occupational medicine	70%	30%	36%	64%	76%	10%	14%	16%	84%
Total*	**68%**	**32%**	**63%**	**37%**	**60%**	**15%**	**24%**	**31%**	**69%**

Almost half of male specialists were in either general medicine or surgery; just over half of female specialists were in general medicine, psychiatry or anaesthetics and intensive care (webappendix page 7). During 2010–13, the population of female specialists grew at more than double the rate of male specialists (21% versus 9%), with a growth of 42% in surgery compared with 12% for male doctors. Nevertheless, female doctors still only made up 10% of surgeons.

The number of female doctors in emergency medicine rose by 44% during 2010–13, compared with 28% for male doctors. Female doctors made up 30% of doctors in emergency medicine in 2013.

Most doctors on the Specialist Register were UK graduates, but the growth in the number of doctors on the Specialist Register has been driven by a 21% increase in EEA graduates and a 17% increase in IMGs joining the Specialist Register during 2010–13 (webappendix page 9). By contrast, the population of UK graduates increased by only 8.5%. The specialists register increased by 7,857 doctors during 2010–13; 2,588 were IMGs (33%), 1,901 were EEA graduates (24%) and 3,368 were UK graduates (43%).

When doctors with unknown ethnicity were excluded, BME doctors made up 31% of the Specialist Register, compared with 36% of the medical register overall.

Of all BME specialists, 52% chose to go into one of the large specialty groups – medicine, surgery and anaesthetics and intensive care. A similar proportion of white specialists – 59% – also chose to go into these specialties. By contrast, about double the proportion of BME specialists (8%) chose obstetrics and gynaecology compared with white specialists (4%).

There were just over 70,000 UK licensed doctors on the Specialist Register in 2013 – an increase of 12% since 2010 (table 2). The number of specialists who were EEA graduates grew by 21%, and IMGs by 18%, compared with a growth of only 8.5% in UK graduate specialists.

Just under 70% of specialists were male. Webappendix pages 7–10 show the number of doctors with each demographic characteristic in each specialty group, and the percentage change in the number of doctors over three years (2010–13).

SPECIALTY GROUP	Number of doctors	Three-year % change (2010–13)
Medicine	17,735	17%
Surgery	13,101	14%
Anaesthetics and intensive care	9,648	9.4%
Psychiatry	8,136	7.7%
Radiology	5,291	8.8%
Paediatrics	5,085	16%
Obstetrics and gynaecology	3,753	13%
Pathology	2,988	1.4%
Ophthalmology	2,156	17%
Emergency medicine	1,893	33%
Public health	955	-5.2%
Occupational medicine	466	-4.7%
Total*	**71,207**	**12%**

Emergency medicine is one of the smaller specialties but it grew by 33% during 2010–13 – more than any other specialty – following a major recruitment exercise. This is a welcome development given the number of severely stretched departments that were described in several reports as being 'in crisis' in 2013.[16] Part of this increase has been due to an increase in the number of IMGs in emergency medicine by 50% during 2010–13 (webappendix page 9).

The two largest specialties – medicine and surgery, which account for 43% of all doctors on the Specialist Register – also grew faster than the rest. The number of doctors in public health reduced by 5.2% and was the only specialty that has seen a decline in both male and female doctors.

* Excludes 254 doctors with old specialties that do not fit into the 12 defined specialty groups.

FIGURE 21: Age and gender of doctors on the Specialist Register in 2013

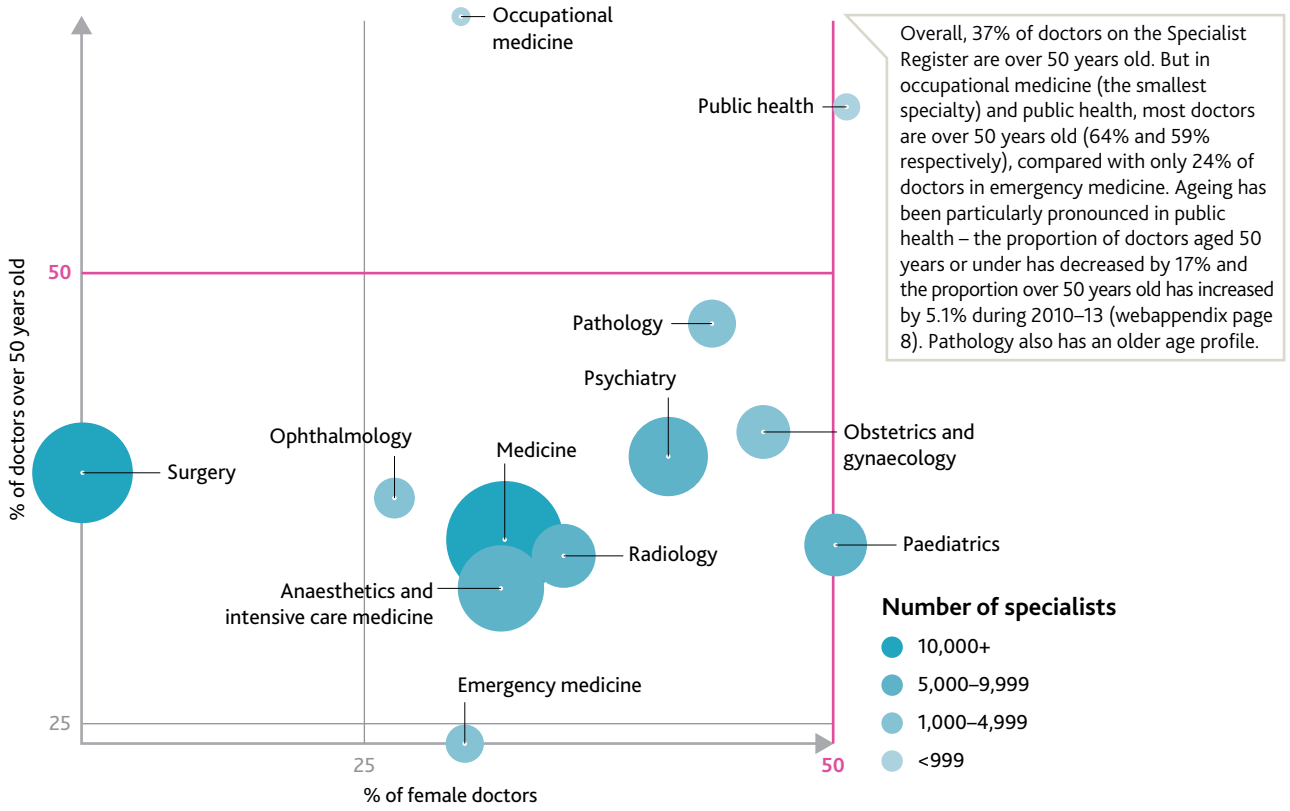
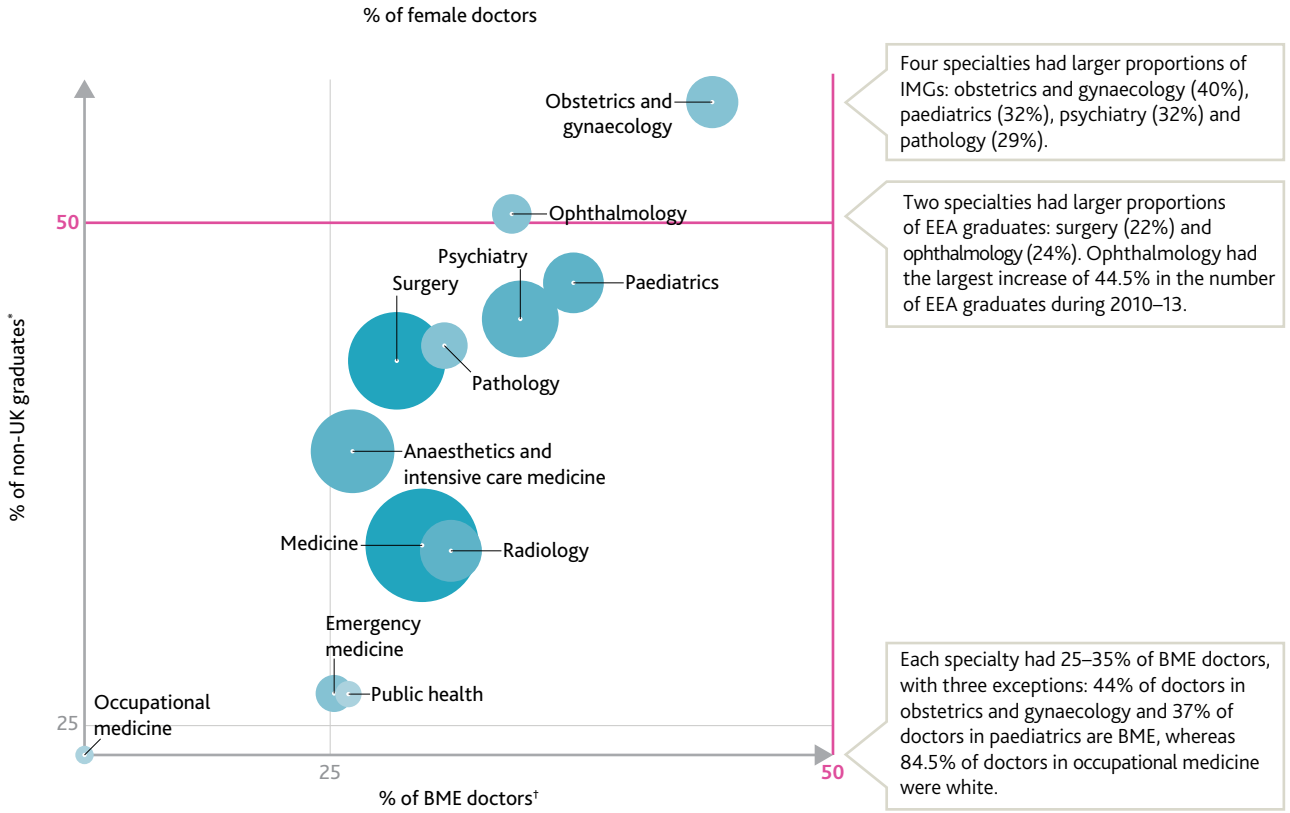


FIGURE 22: Place of primary medical qualification and ethnicity of doctors on the Specialist Register in 2013



* Includes EEA graduates and IMGs.

† Excludes doctors with unknown ethnicity.

Section 7: Joiners and leavers

During 2013, 13,150 doctors joined the medical register for the first time and took up a licence to practise (joiners), and 12,231 gave up their licence and stopped practising in the UK (leavers). Webappendix pages 11–12 show the demographic characteristics of joiners and leavers in 2013.

Figure 23 shows the countries where doctors joining the medical register in 2013 gained their primary medical qualification. Table 3 shows the world regions where these doctors gained their primary medical qualification and how these regions changed during 2008–13 (webappendix page 16 shows this information for each country).

In the past, the number of IMGs joining the register has been much higher than the number of EEA graduates and, as a result, there were more IMGs than EEA graduates on the register in 2008. But this trend is now switching: in 2013, many more EEA graduates joined than IMGs, and about 50% more IMGs gave up their licence than EEA graduates. As a result, from 2012 to 2013 the number of IMGs fell by 1,666, and the number of EEA graduates grew by 317. However, the biggest increase was among UK graduates, with a net increase of 2,268.

TABLE 3: World regions where doctors joining the medical register gained their primary medical qualification, ranked by the numbers joining in 2013*

	WORLD REGIONS†	Doctors who joined in 2008		Doctors who joined in 2013		Difference for 2008–13	
		Number of doctors	% of doctors	Number of doctors	% of doctors	Number of doctors	% of doctors
1	Southern Europe (EEA)	920	18%	1,840	33%	920	100%
2	South Asia	1,483	28%	1,125	20%	-358	-24%
3	Northwestern Europe (EEA)	575	11%	651	12%	76	13%
4	Central Europe, eastern Europe and Baltic Countries (EEA)	675	13%	632	11%	-43	-6.4%
5	Africa	576	11%	424	7.6%	-152	-26%
6	Middle East	449	8.6%	320	5.7%	-129	-29%
7	Oceania	97	1.9%	161	2.9%	64	66%
8	South, Central and Latin Americas, and the Caribbean	91	1.7%	161	2.9%	70	77%
9	Non-EEA Europe	158	3.0%	124	2.2%	-34	-22%
10	Rest of Asia	130	2.5%	98	1.7%	-32	-25%
11	Northern America	38	0.7%	50	0.9%	12	32%
12	China	12	0.2%	33	0.6%	21	175%
	Total	**5,204**	**100%**	**5,619**	**100%**	**415**	**8.0%**

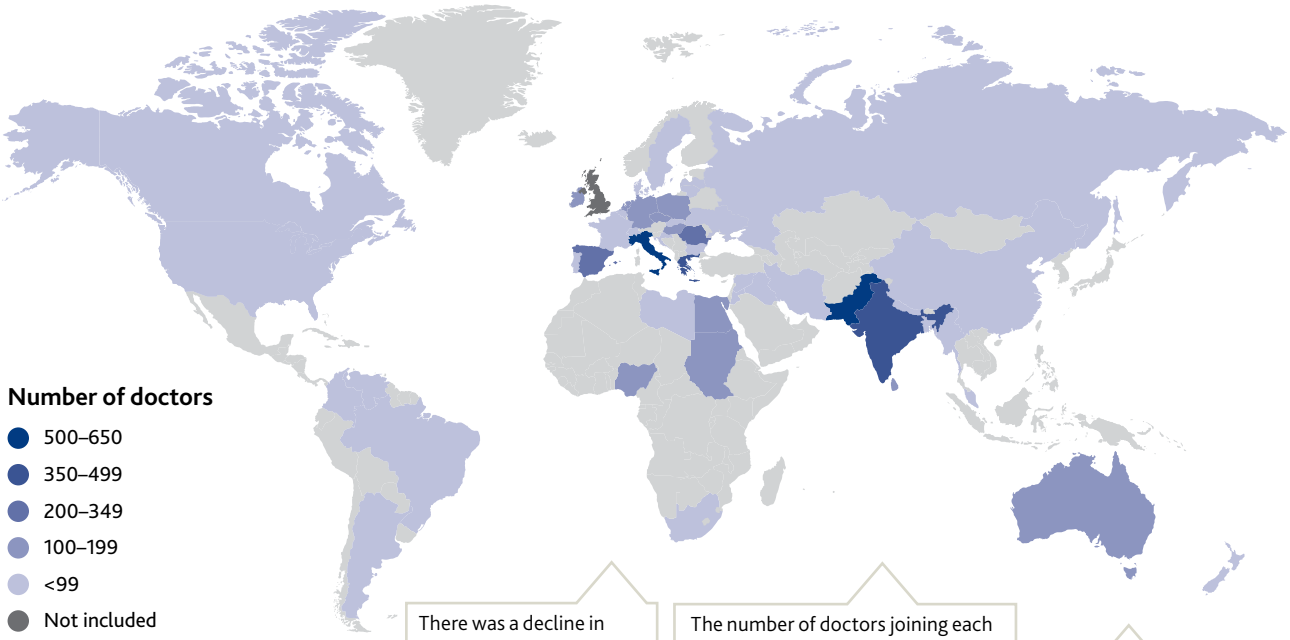
* Excludes UK graduates.

† For a list of countries in each region, see the data note on page 154.

FIGURE 23: Countries where doctors joining the medical register in 2013 gained their primary medical qualification*

In Europe, the only region where the number of joiners increased dramatically during 2008–13 was southern Europe. Two countries – Italy and Greece – accounted for 20% of all non-UK graduates joining the medical register in 2013 (webappendix page 16). This was almost certainly the result of the economic and labour market situations in these countries.

There was a small decline in the number joining from central Europe, eastern Europe and the Baltic Countries, and a relatively small increase in the number joining from northwestern Europe. Within this increase, the number of joiners from Ireland increased by over 50% during 2008–13 and in 2013 constituted over 3% of all doctors joining (webappendix page 16).



There was a decline in doctors joining from the Middle East and Africa, which have previously supplied relatively large numbers of doctors to the UK.

The number of doctors joining each year from southern Europe doubled between 2008 and 2013. At the same time, the number from south Asia – which for many years provided many doctors to the UK – declined by nearly 25% to 1,125 in 2013. This means the number of doctors joining from southern Europe exceeded the numbers joining from south Asia. The fall was particularly notable for joiners from India – down by nearly a half compared with 2008 (webappendix page 16).

Few doctors join from Oceania and South, Central and Latin America and the Caribbean, but there was a sharp increase in the number of doctors joining from both regions during 2008–13.

* Excludes UK graduates.

Expansion of the EEA is not the main reason for recent increase in doctors joining from Europe

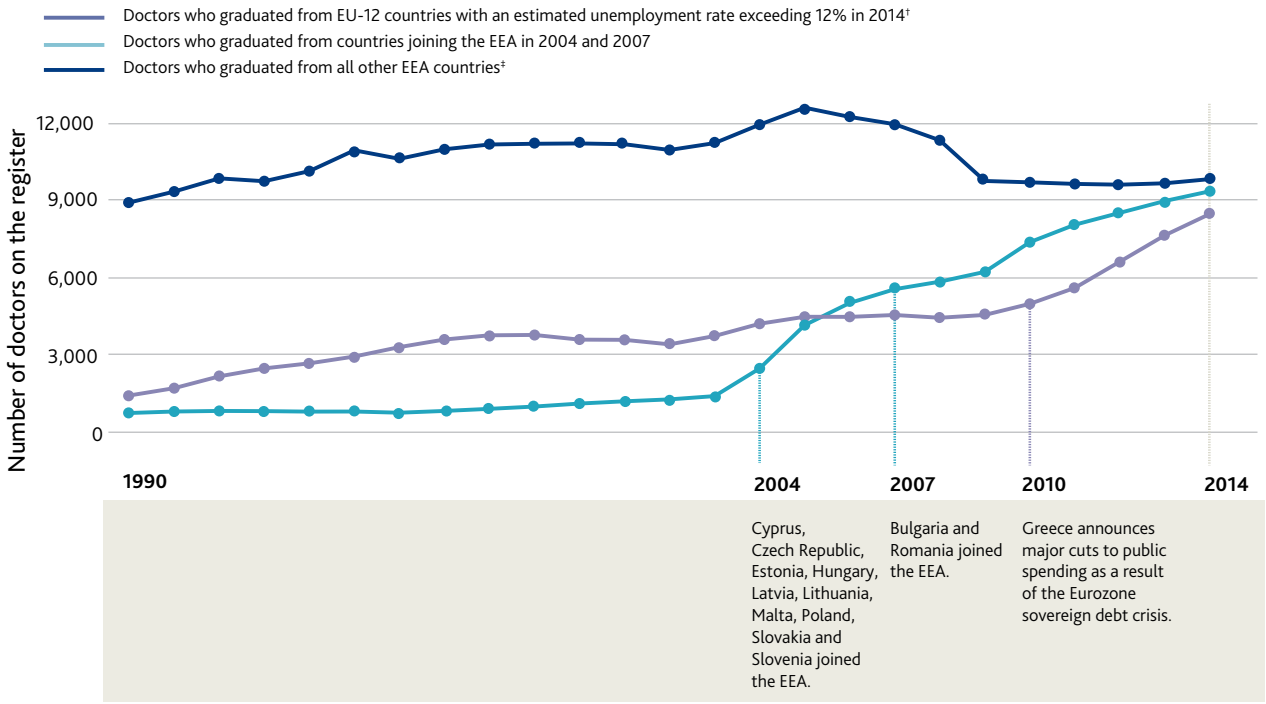
The proportion of EEA graduates on the medical register has grown over the past 25 years: from 5.9% in the early 1990s to 11% in 2013.

Table 3 (page 54) shows the number of doctors joining the register from southern Europe increased significantly during 2008–13. The current surge from this area is likely to be primarily the result of the difficult economic and labour market situations in these countries.

Most recently this does not seem to be just a product of the increasing size of the EEA. However, on joining the EEA more doctors from those countries do begin to work in the UK. Figure 24 shows the number of doctors on the medical register who were EEA graduates follows a similar trend whether we restrict the data to countries joining the EEA in 2004 and 2007, or restrict the data to countries with higher unemployment rates.

The proportion of joiners who were UK graduates or IMGs did not have a similarly steady increase. UK graduates rose from around 63% in the early 1990s to a peak of around 67% in the early 2000s, and then declined back to around 63% in 2013. IMGs declined from around 30% in the early 1990s to around 24% at the turn of the century, and then rose a little to around 26% in 2013.

FIGURE 24: **Change in the number of doctors on the register who are EEA graduates (1990-2013)***



* Excludes UK graduates.

† Data for Greece, Italy, Portugal and Spain are from the International Monetary Fund – www.imf.org/external/pubs/ft/weo/2014/01/weodata/index.ospx.

‡ Austria, Belgium, Denmark, Finland, France, Germany, Iceland, Ireland, Netherlands, Norway, Sweden and Switzerland.

Moving abroad and retiring are the most common reasons doctors stop working in the UK

Webappendix pages13–14 set out the reasons doctors gave up their licence to work in the UK in 2013, separated by their place of primary medical qualification and age. 23% of doctors did not give a reason for giving up their licence to work in the UK. 40% of EEA graduates and 24% of IMGs did not give a reason, compared with only 14% of UK graduates.

Of the 9,382 doctors who gave a reason for leaving, the two most common were moving overseas and retirement. 81% of doctors aged 50 years and under were moving overseas and less than 1% were retiring. Whereas 65% of those over 50 years old were retiring and 22% were moving overseas.

Unsurprisingly, 68% of EEA graduates and 71% of IMGs were moving overseas, perhaps returning to home countries, compared with only 33% of UK graduates. 52% of UK graduates were retiring, compared with only 8% of EEA graduates and 18% of IMGs.

2.5% of doctors aged 50 years and under and 3.5% of those over 50 years old cited revalidation. The proportion was higher for non-UK graduates than for UK graduates. 2.8% of doctors aged 50 years and under cited maternity or paternity.

Australia and New Zealand are the most popular destinations

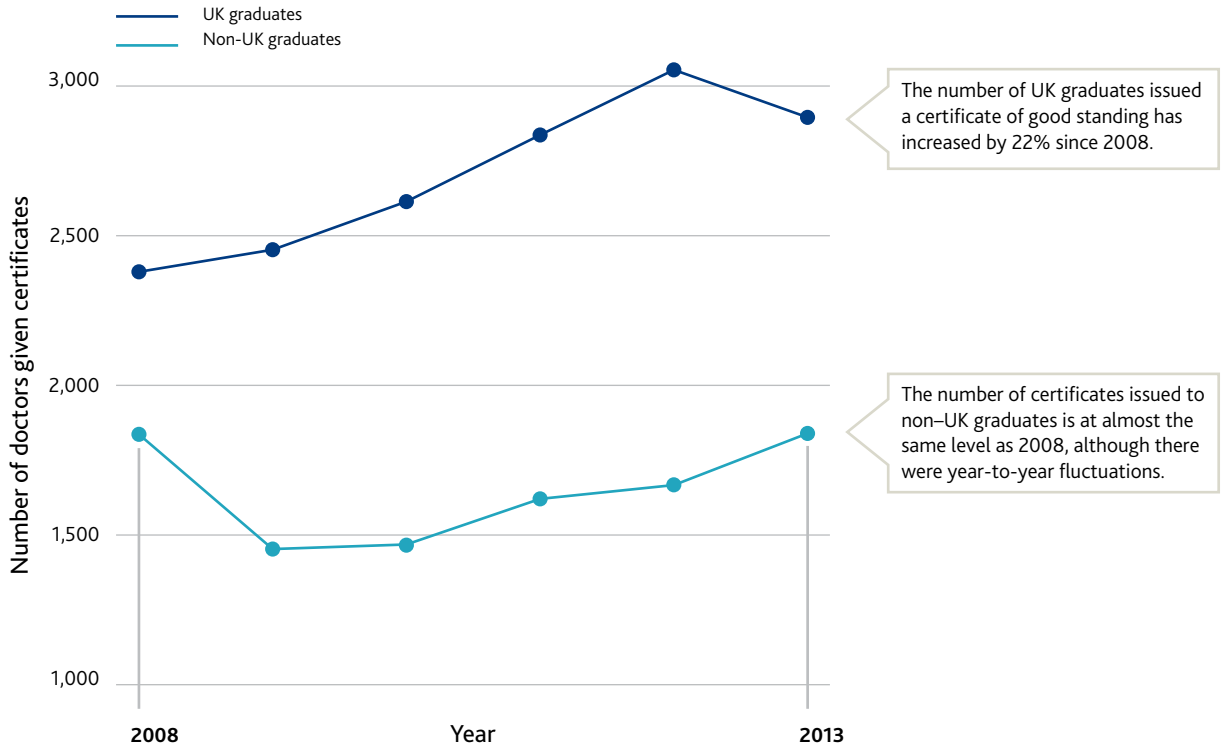
When doctors working in the UK register to work in another country, they usually need a certificate of good standing from the GMC. Doctors who request a certificate do not always end up going abroad and, of those who do, some only leave temporarily, to further their training or experience for a short period. Nevertheless, trends in the numbers of certificates issued to overseas regulators give an indication of doctors moving out of the UK (figure 25).

Most requests for certificates in 2013 were for doctors aged 25–27 years – these doctors accounted for 926 of the 4,741 certificates issued to overseas regulators (20%).

Certificates are usually issued for registration on a specific country's register, which gives an indication of where doctors are going. 51% of doctors given a certificate in 2013 had them sent to two countries – Australia and New Zealand. A further 9.7% went to Canada, 8% went to three countries in east Asia (Hong Kong, Malaysia and Singapore), 6.7% went to Ireland and 4.9% went to the United Arab Emirates.

The dominance of Australia and New Zealand has declined from 61% in 2008 to 51% in 2013. The shares of Canada, Ireland and South Africa have also fallen a little, while the share of the three east Asian countries (and other countries to which only very small numbers of certificates are issued) have increased, suggesting an increase in the diversity of countries to which doctors working in the UK are choosing to go.

FIGURE 25: Change in the number of doctors certificates of good standing to be issued to overseas regulatory bodies (2008–13)



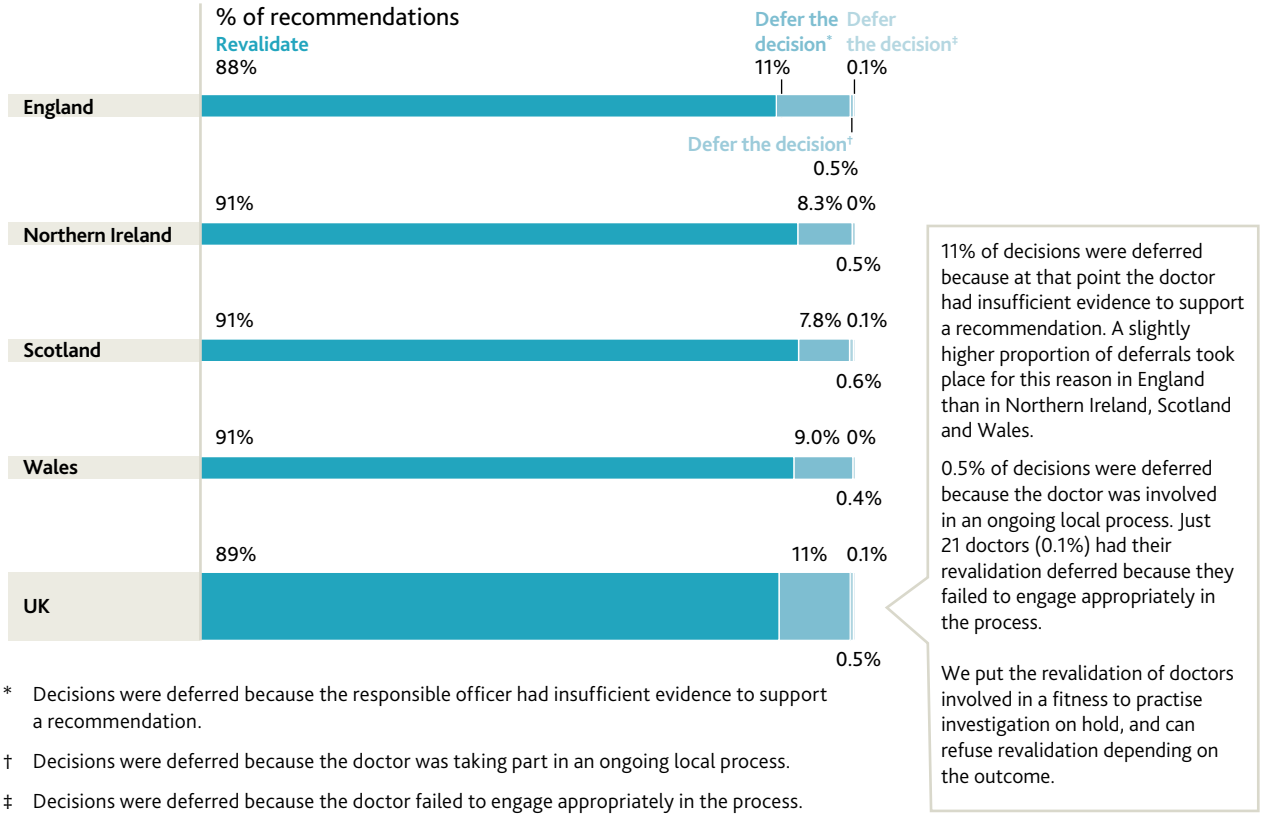
Section 8: Revalidation

We have received 48,655 revalidation recommendations

We introduced revalidation for all licensed doctors at the end of 2012. This is a system of regular checks to make sure doctors are keeping their skills and knowledge up to date, and are able to deliver safe and effective care. Every five years, the doctor's responsible officer recommends to the GMC that we should revalidate the doctor, defer the decision or revoke the doctor's licence to practise. By 30 April 2014, 223,843 doctors were taking part in revalidation[13] and we had received revalidation recommendations for 48,655,§ of whom 38,486 were not in training. Of those not in tranining, nearly 90% of the recommendations were for the doctor to be revalidated (figure 26).

Deferring the decision is a neutral act that has no effect on a doctor's licence to practise, and gives the doctor more time to gather and present evidence supporting that they can revalidate. A wide range of circumstances, such as maternity leave, can lead to a deferral.

FIGURE 26: Responsible officers' recommendations on whether 38,486 doctors who were not in training could revalidate (December 2012–30 April 2014)



11% of decisions were deferred because at that point the doctor had insufficient evidence to support a recommendation. A slightly higher proportion of deferrals took place for this reason in England than in Northern Ireland, Scotland and Wales.

0.5% of decisions were deferred because the doctor was involved in an ongoing local process. Just 21 doctors (0.1%) had their revalidation deferred because they failed to engage appropriately in the process.

We put the revalidation of doctors involved in a fitness to practise investigation on hold, and can refuse revalidation depending on the outcome.

* Decisions were deferred because the responsible officer had insufficient evidence to support a recommendation.

† Decisions were deferred because the doctor was taking part in an ongoing local process.

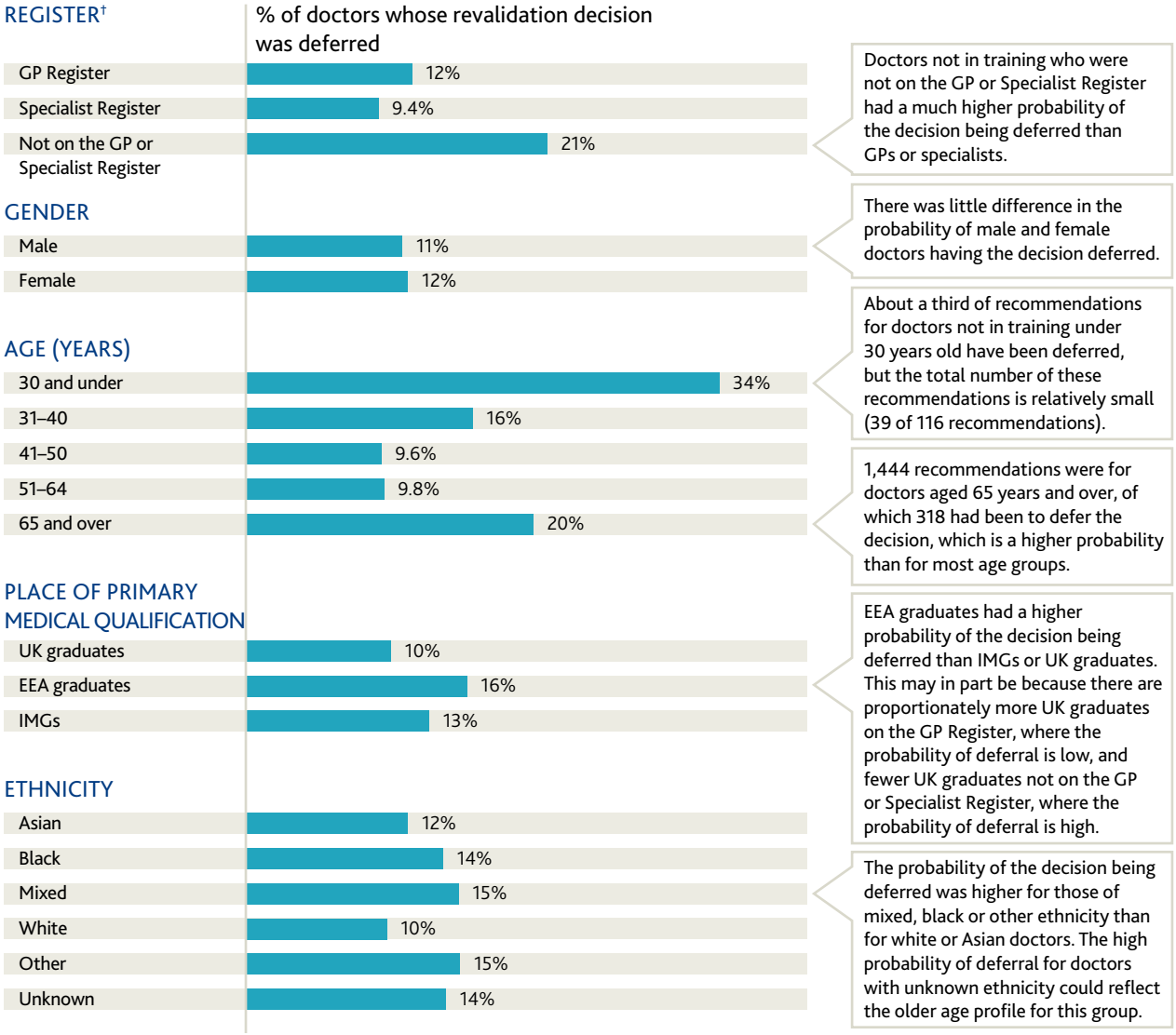
‡ Decisions were deferred because the doctor failed to engage appropriately in the process.

§ We excluded about 8,000 doctors who were provisionally registered or registered on a temporary or occasional basis, and about 2,000 doctors whose revalidation status was on hold because they were involved in open fitness to practise cases.

Certain groups of doctors have a higher probability of deferral

Some groups of doctors not in training have a higher probability of their revalidation decision being deferred (figure 27): doctors not in training who are not on the GP or Specialist Register, doctors not in training aged 30 years and under, doctors aged 65 years and over, EEA graduates and doctors of mixed and other ethnicity.

FIGURE 27: **Probability of doctors not in training having their revalidation decision deferred***



* Includes all recommendations where a doctor not in training had multiple recommendations (eg deferral followed later by a positive recommendation).

† Excludes the very small number of doctors on both the GP and the Specialist Registers.

Section 9: How we handle complaints about doctors

We receive about 10,000 enquiries about doctors every year, of which over 80% are complaints about a doctor's fitness to practise. From these, we have to decide whether we need to investigate the doctor's fitness to practise and, if so, whether we need to take any action as a result. Figure 28 sets out how we handled the enquiries we received in 2013.

Complaints come from a variety of sources, including the public, employers and other doctors. In section 10 (page 66), we explore how the sources of complaints have changed over the four-year period from 2010 to 2013.

The complaints may raise different allegations about a doctors' fitness to practise, from clinical competence to issues of honesty and fairness – section 11 (page 69) looks at the relative importance of different types of allegation.

Section 12 (page 72) looks at how the level of complaints differs between doctors in different areas of practice and with different characteristics.

Sometimes there are multiple complaints against a doctor from one complainant. In section 13 (page 84), we examine the extent of this.

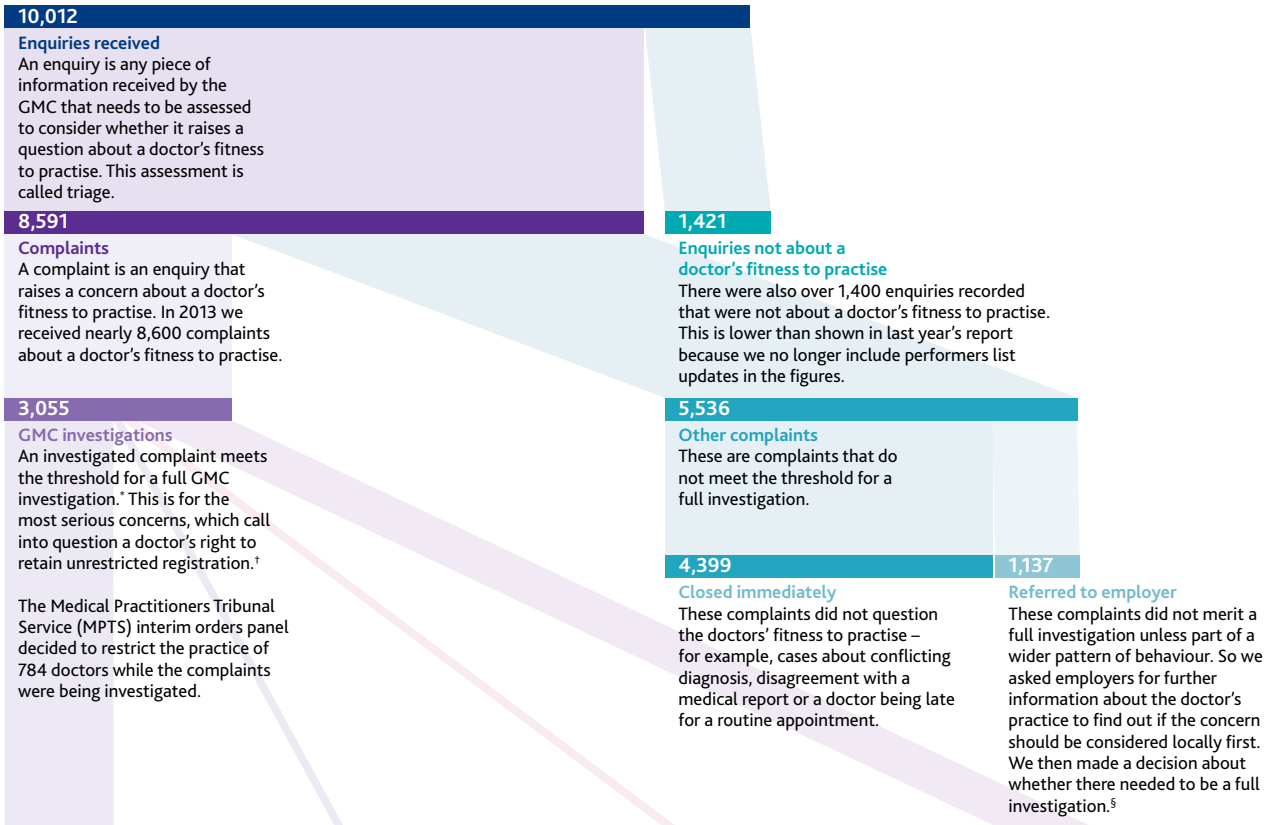
NOTE ON DATA: sections 9–13

Data for 2012 and earlier years differ slightly from the data in last year's edition of this report. This is caused by retrospective updates to the data where new information is received about additional doctors on existing complaints. The scale of this is relatively small: we recorded 8,109 complaints in 2012 in last year's report, compared with 8,125 complaints in 2012 on the basis we have used this year.

In sections 10–13 of this chapter and in chapter 2, we pool data across four years from 2010 (the first full year after licensing was introduced) to 2013, rather than across the six years (2007–12) used in chapter 3 of last year's report. It is important to remember this when comparing the numbers of investigations, sanctions and warnings.

If a doctor was complained about more than once over the four-year period, in sections 9–12 we included data for the most serious outcome only, so the number of complaints is equal to the number of doctors complained about.

FIGURE 28: How we handled enquiries about doctors in 2013



* In previous editions of this report, this type of complaint is referred to as 'stream 1'.

† These are complaints about: a doctor's conduct and professional performance (eg serious or persistent clinical errors, failures to provide appropriate treatment or care, serious breaches of our guidance); serious impairment of a doctor's practice because of physical or mental ill health; a doctor receiving a conviction or caution inside or outside the UK; or a doctor being a risk to patients.

‡ These included 70 resolved cases of voluntary erasure and nine resolved cases of administrative erasure, and 11 cases where the complaint has been withdrawn.

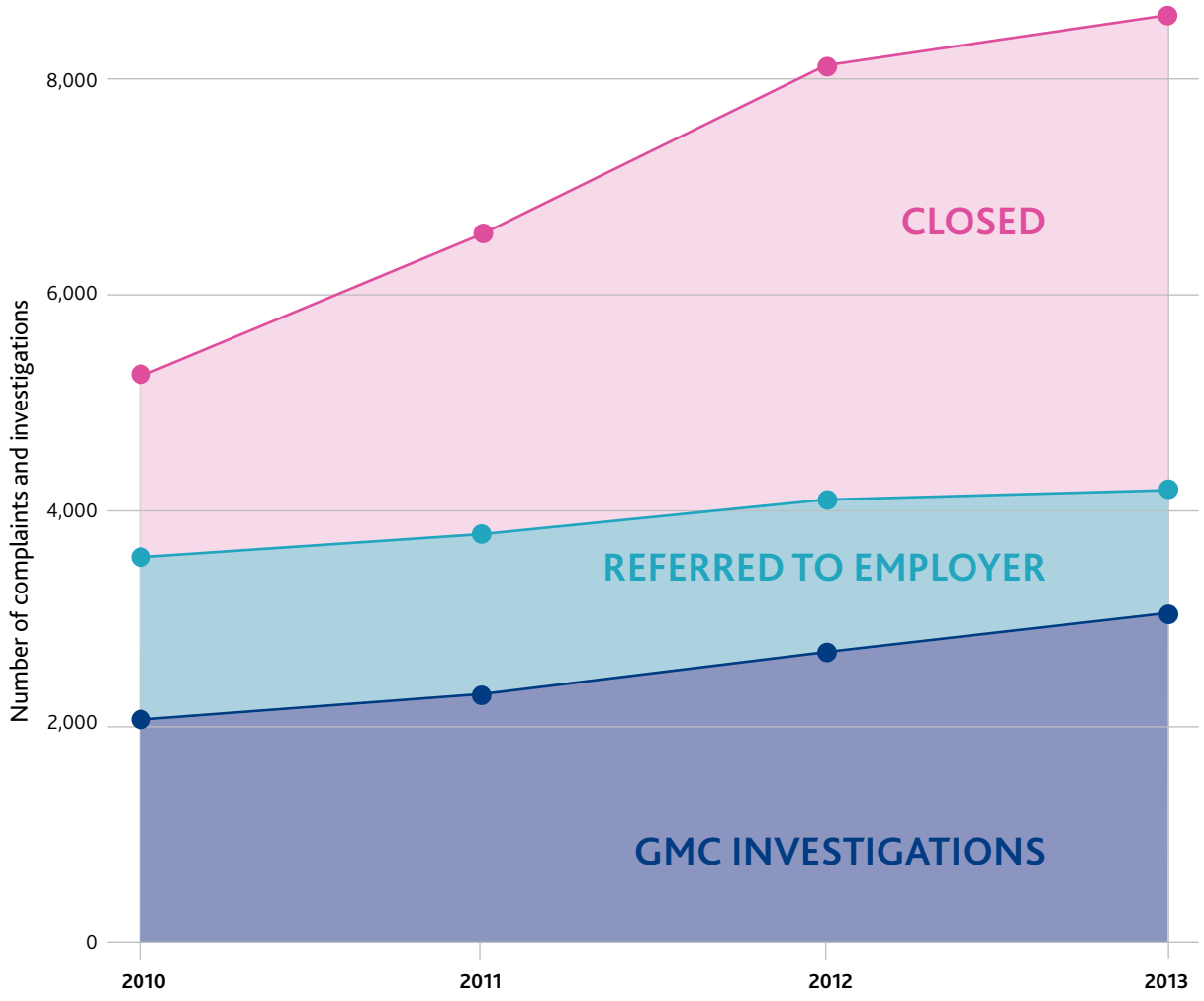
§ In previous editions of this report, this type of complaint is referred to as 'stream 2'.

¶ These decisions will be taken by the MPTS fitness to practise panel. In some cases, case examiners are able to issue a warning or agree an undertaking with the doctor after the investigation.

The increase in complaints is slowing down

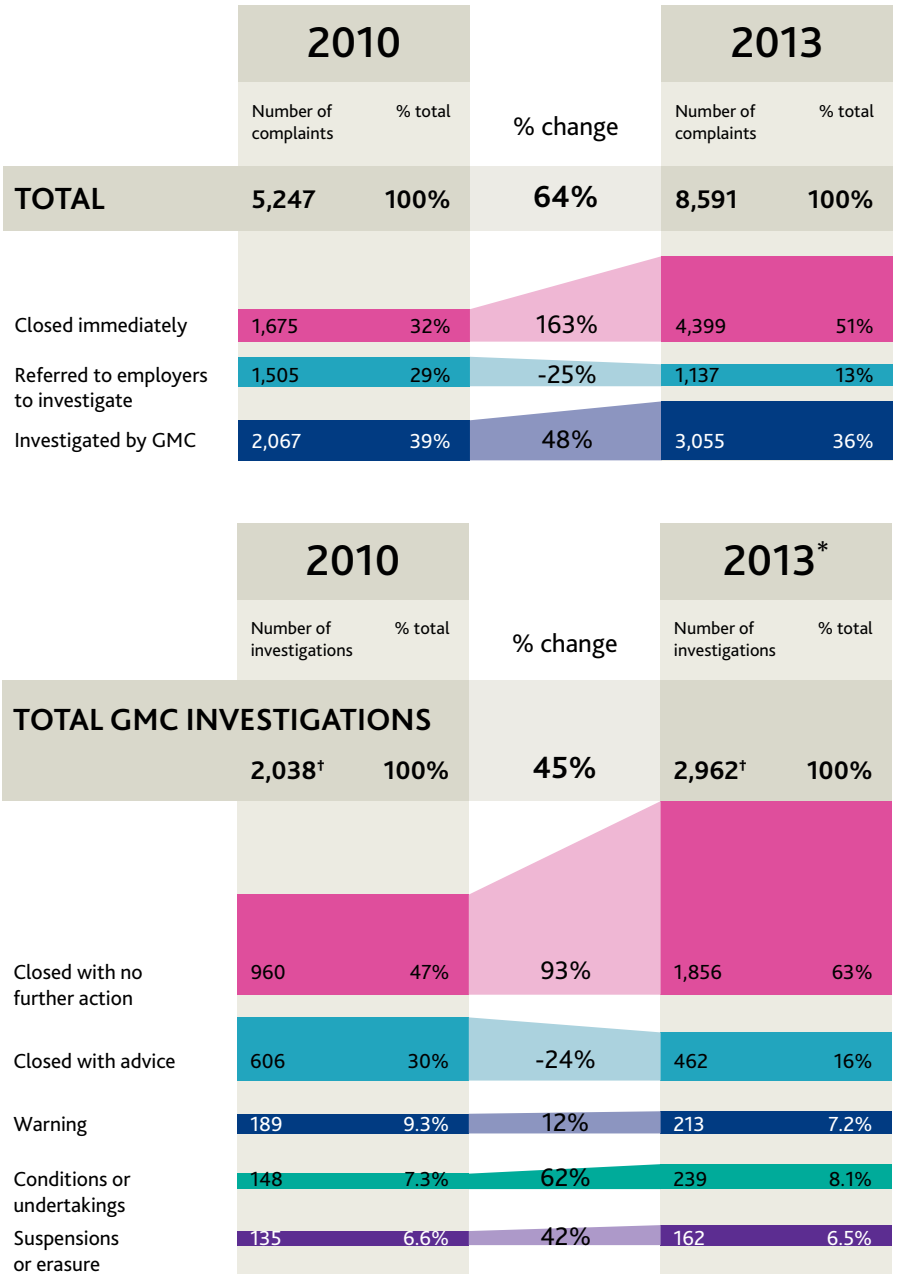
There were 8,591 complaints about a doctor's fitness to practise in 2013 – 5.7% higher than in 2012 (figure 29). This is a sharp fall in the rate of increase over recent years: there was a 25% rise from the previous year in 2011 and a 24% rise in 2012. But the number of complaints was still 64% higher in 2013 than in 2010, representing a very rapid increase in the number of complaints we process.

FIGURE 29: **Increase in the number of complaints and investigations 2010–13**



The number of full investigations by the GMC is nearly 50% higher than three years ago

FIGURE 30: **Change in how we handled the complaints we received during 2010–13**



The number of complaints closed immediately has risen sharply since 2010 to represent half of those we received in 2013. The steepest increase was from 32% in 2010 to 50% in 2012, and levelled off to 51% in 2013.

Of the complaints that were not closed immediately, we referred a lower proportion to employers and investigated a higher proportion. We investigated more than 3,000 complaints in 2013 – about a third of those received. This represents a rise of 13% since 2012 and nearly 50% since 2010.

* To calculate these data we have modelled the outcomes of the 1,289 cases still unresolved, six months after the end of 2013, on the basis that they would result in proportionately the same outcomes as cases opened in 2010 that were still being investigated six months after the end of that year.

† Excludes cases where the outcome is unknown.

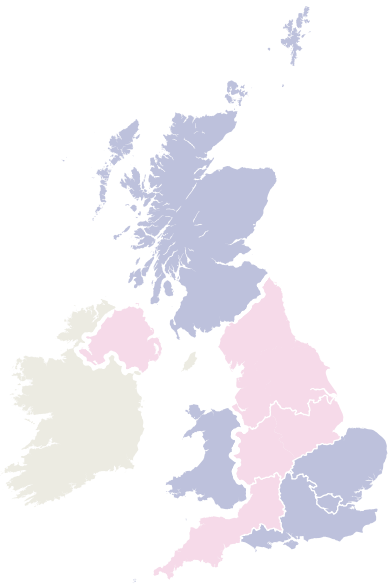
Section 10: The source of complaints

In 2013, 65% of complaints came from the public, just over 12% from other doctors, 6% from employers and 17% from other sources. These proportions changed little between 2010 and 2013.

In this section, we use pooled data for the four-year period 2010–13 so that the numbers are sufficiently large to be meaningful. Over this time, there were 28,531 complaints, of which we investigated 10,080. Figure 31 shows where these complaints came from across the UK.

Of all sanctions and warnings given during 2010–13, only 11% originated from public complaints, even though the public accounted for 64% of complaints. 56% originated from complaints by the medical profession – 29% from doctors and 27% from employers.

FIGURE 31: **Where complaints came from across the UK during 2010–13, by source**



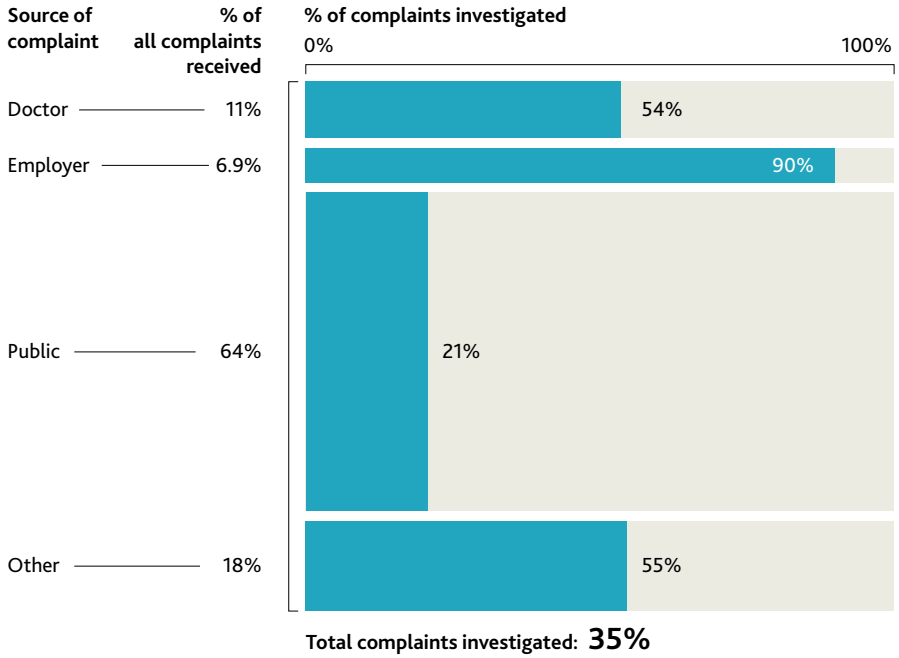
Index of complaints from the public relative to the UK average of 100

- >140
- 120–139
- 100–119
- 80–99
- 60–79
- <59

PART OF THE UK	Total number of complaints	Number of complaints by source			
		Doctor	Employer	Public	Other
North	4,588	610	379	2,800	799
East and West Midlands	2,904	314	240	1,875	475
East	2,079	256	153	1,399	271
London	4,689	517	254	3,210	708
Southeast	2,939	322	136	2,100	381
Southwest	1,154	155	76	759	164
England (total)	18,353	2,174	1,238	12,143	2,798
Northern Ireland	413	80	31	220	82
Scotland	1,507	231	57	994	225
Wales	824	105	62	541	116
UK	21,097	2,590	1,388	13,898	3,221
UK (including doctors with unknown location)	28,531	3,231	1,957	18,204	5,139

There is little regional difference in the proportion of complaints coming from each source across regions of England. But, in Northern Ireland, the proportion of complaints from doctors (19%) was double the UK average (11%), and the proportion of complaints from the public (53%) was substantially lower than the UK average (64%). In Scotland, the proportion coming from employers was low (3.8%) compared with the UK average (7%).

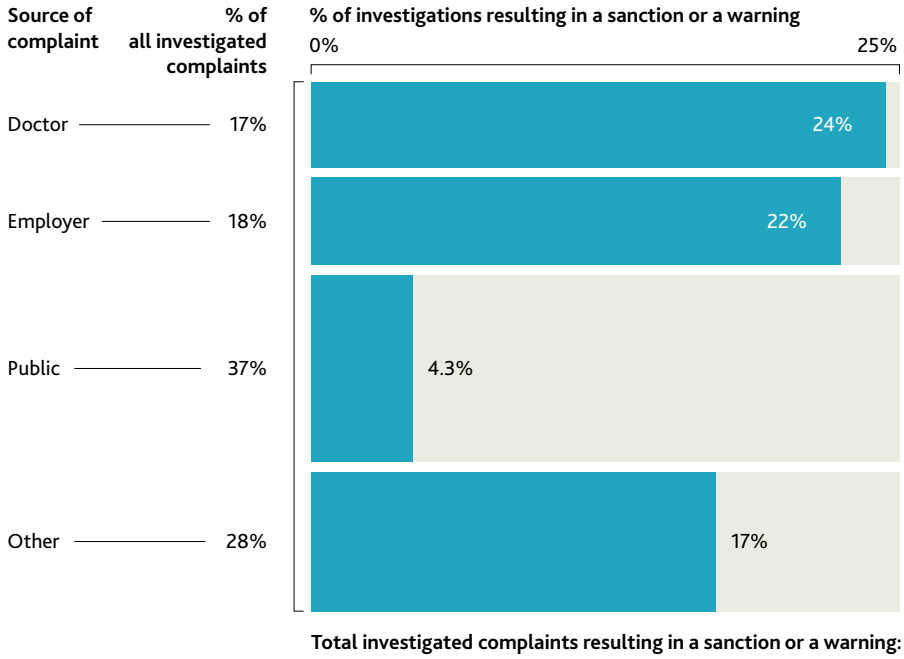
FIGURE 32: Proportion of complaints that we investigated in 2010–13, by source



326 of the cases opened during 2010–13 led to the doctor being suspended or erased – an average of just over 80 serious sanctions per year. Of the complaints that led to suspension or erasure, 33% originated from employers, 14% from doctors and 8% from the public. 45% originated from other sources, including the police, partly because criminal convictions are much more likely to lead to a severe sanction.

A low proportion of patient complaints from the public led to a serious outcome: 79% were closed immediately or referred to employers. The remaining 3,767 complaints were investigated and, of those, just 161 (4.3%) led to a sanction or a warning. This means that less than 1% of complaints from the public resulted in a sanction or a warning, and only 0.1% led to suspension or erasure. By contrast, 397 complaints from employers (20%) and 424 complaints from other doctors (13%) led to a sanction or a warning.

FIGURE 33: Proportion of investigated complaints that resulted in a sanction or a warning in 2010–13, by source*



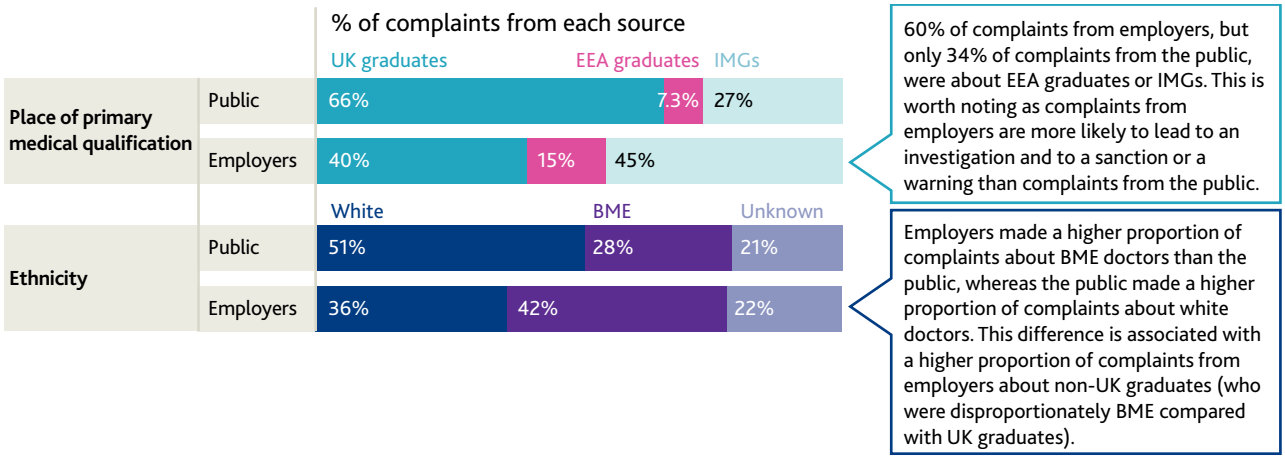
About a quarter of investigated complaints from employers or other doctors resulted in a warning or sanction (condition, undertaking, suspension or erasure).

Fewer than one in 20 investigated complaints from members of the public resulted in a sanction or a warning.

* Some of the investigations still unresolved at the end of June 2014 will also result in a sanction or a warning. When all cases are resolved the propotion of investigations leading to a sanction or a warning will be slightly higher than shown here.

Employers make a higher proportion of complaints about BME doctors than the public

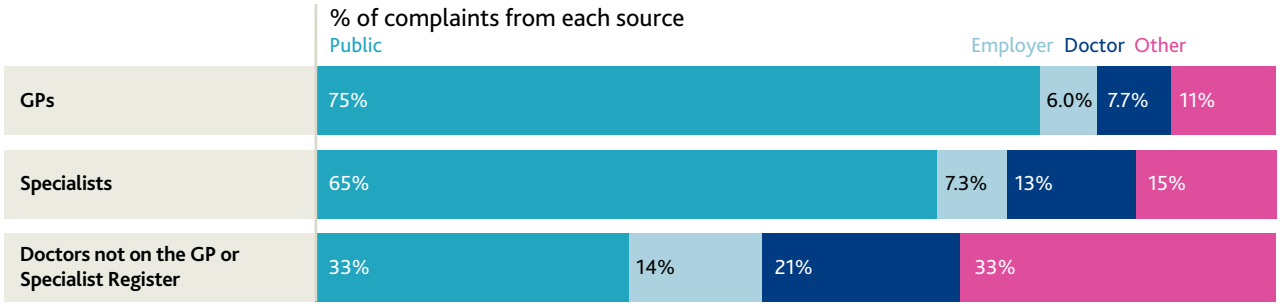
FIGURE 34: Personal characteristics of doctors who are complained about by the public and employers, 2010–2013



60% of complaints from employers, but only 34% of complaints from the public, were about EEA graduates or IMGs. This is worth noting as complaints from employers are more likely to lead to an investigation and to a sanction or a warning than complaints from the public.

Employers made a higher proportion of complaints about BME doctors than the public, whereas the public made a higher proportion of complaints about white doctors. This difference is associated with a higher proportion of complaints from employers about non-UK graduates (who were disproportionately BME compared with UK graduates).

FIGURE 35: Source of complaints about GPs or specialists or doctors who are neither, 2010–2013



The vast majority of complaints about GPs and about specialists came from the public (75% and 65% respectively); however as noted above the public accounted for only about 1 in 10 of complaints leading to a suspension or erasure of these doctors. This is because so many were closed immediately. Those doctors on neither register, which included doctors in training, had a much smaller proportion of complaints from the public (33%) and a much larger proportion of complaints about them from employers and other doctors (35%).

Section 11: Types of allegation

When the GMC decides a case needs investigating further, either by employers or by us, we set out the allegations involved from a list of about 300. Cases are often complicated and involve more than one allegation.

To aid analysis, we have grouped the allegations into eight broad types. What each of these types includes is shown in figure 36. In figure 39 (page 71) we look at the individual allegations within these groups.

FIGURE 36: **Types of allegation in cases we investigate**

Health	Substance misuse
	Mental and behavioural issues
	Other health issues affecting judgement
Criminality	Violence
	Sexual issues
	Harassment
	Motoring offences
	Fraud
	Other criminal activities
Acting honestly and fairly	Failure to act with honesty and integrity
	Treating or prescribing themselves or friends
	Unfairness or discrimination
Professional performance	Failure to follow guidance, codes or regulations
	Inadequate training and knowledge
	Inadequate leadership
	Poor record keeping
	Inefficient use of resources
Clinical competence	Bad judgement of own abilities
	Poor diagnosis and examination
	Prescribing problems
	Other clinical issues
Communication and respect for patients	Lack of appropriate communication
	Failure to coordinate care
	Lack of respect for patients
Working with colleagues	Not meeting teaching or training responsibilities
	Not working well with colleagues
Safety and quality systems	Inadequate use of safety and quality systems
	Inadequate response to risks
	Delay or failure to raise concerns

Criminality and health cases are more likely to be investigated by the GMC, and to lead to a sanction or a warning

FIGURE 37: What are the most common types of allegation investigated by employers and the GMC?

TYPES OF ALLEGATION	Number of cases investigated: Total	Number of cases investigated: Referred to employers to investigate	Number of cases investigated: Investigated by the GMC	% investigated by the GMC
Criminality	1,196	8	1,188	99%
Health	899	34	865	96%
Acting honestly and fairly	3,972	988	2,984	75%
Working with colleagues	1,106	271	835	76%
Professional performance	2,766	736	2,030	73%
Safety and quality systems	526	178	348	66%
Clinical competence	8,176	3,840	4,336	53%
Communication and respect for patients	5,216	3,057	2,159	41%
Unspecified*	1,986	49	1,937	

Almost all criminality and health cases were fully investigated by the GMC, rather than being sent back to employers. By contrast, cases about clinical competence or about communication and respect for patients were much more likely to be referred back to employers.

* Unspecified cases are primarily those that are under investigation with no allegation type yet allocated, or where the case has been closed because the complainant has not given consent to disclose information.

Figure 38: Outcomes of cases investigated by the GMC

TYPES OF ALLEGATION	Cases fully investigated by the GMC	Outcomes of fully investigated cases: % of investigations leading to the most serious sanctions: a suspensionor an erasure	Outcomes of fully investigated cases: % of investigations leading to any sanction or a warning
Health	865	5.3%	50%
Criminality	1,188	7.6%	43%
Acting honestly and fairly	2,984	7.0%	21%
Professional performance	2,030	3.9%	17%
Working with colleagues	835	4.5%	15%
Communication and respect for patients	2,159	3.0%	11%
Safety and quality systems	348	2.6%	9.5%
Clinical competence	4,336	1.9%	9.6%

A higher proportion of cases about criminality or health led to a sanction or a warning. Cases about criminality or acting honestly and fairly were more likely to lead to the most serious sanctions of a suspension or erasure.

Health cases are most likely to lead to a sanction or a warning, but criminality cases are most likely to lead to suspension or erasure

FIGURE 39: **Top ten types of allegation leading to a sanction or a warning, or to suspension or erasure, after the GMC has investigated**

Sanction or warning TYPES OF ALLEGATION	Total number of cases	Number of cases leading to a sanction or a warning	% leading to a sanction or a warning
Health – substance misuse	305	193	63%
Health – mental and behavioural issues	538	275	51%
Criminality – motoring offences*	496	252	51%
Criminality – other criminal activities	71	36	51%
Criminality – fraud	132	65	49%
Criminality – violence	325	116	36%
Criminality – sexual issues	110	33	30%
Criminality – harassment	44	13	30%
Professional performance – inadequate training and knowledge	439	124	28%
Acting honestly and fairly – failure to act with honesty and integrity	2,433	558	23%

Of cases investigated by the GMC, cases involving allegations about substance misuse were most likely to lead to a sanction or a warning. Cases about mental and behavioural issues, motoring offences and fraud were also highly likely to lead to a sanction or a warning.

Suspension or erasure TYPES OF ALLEGATION	Total number of cases	Number of cases leading to a suspension or erasure	% leading to suspension or erasure
Criminality – sexual issues	110	20	18%
Criminality – fraud	132	22	17%
Criminality – harassment	44	6	14%
Acting honestly and fairly – failure to act with honesty and integrity	2,433	191	7.9%
Criminality – violence	325	23	7.1%
Professional performance – inadequate training and knowledge	439	29	6.6%
Health – substance misuse	305	20	6.6%
Health – mental and behavioural issues	538	28	5.2%
Working with colleagues – not working well with colleagues	667	32	4.8%
Criminality – other criminal activities	71	3	4.2%

Of cases investigated by the GMC, cases involving allegations about sexual issues were most likely to lead to suspension or erasure. Cases about fraud and harassment were also highly likely to lead to suspension or erasure.

* 54 cases that also involved health issues as well as a motoring offence. When excluding these only a small number of motoring offences (5.2%) led to sanction with the remaing cases either being closed (55%) or resulting in a warning (40%).

Section 12: Outcomes for different cohorts of doctors

In last year's report, we found differences in the proportion being complained about, being fully investigated and receiving a sanction or a warning – between men and women, between age groups, between GPs, specialists and doctors who were neither, and between UK graduates, EEA graduates and IMGs. In this section, we present some key data on the outcomes of our fitness to practise processes for doctors in different cohorts. This year we have included differences between white and BME doctors. We feel confident in publishing data by ethnicity for the first time in this form. Although we do not know the ethnicity of 19% of doctors who were complained about between 2010 and 2013, research we have done recently suggests that this is unlikely to make the comparison unreliable (box 2, page 42).

TABLE 4: Number of doctors who were complained about, had the complaint investigated and received a sanction or a warning in 2010–13, by type of doctor and age

TYPE OF DOCTOR AND AGE (YEARS)		Number of doctors on the medical register	Number of complaints	Number of complaints investigated	Number of complaints leading to a sanction or a warning			
					Warning	Condition	Undertaking	Suspension or erasure
All doctors	<30	35,243	1,103	637	80	1	64	23
GPs	30–50	35,603	3,947	1,280	90	13	65	36
	>50	21,599	4,360	1,586	82	10	83	44
Specialists	30–50	42,634	3,258	1,240	87	4	55	15
	>50	25,139	3,377	1,320	74	7	40	35
Doctors not on the GP or Specialist Register	30–50	60,401	2,387	1,554	146	10	135	92
	>50	11,578	1,027	600	24	1	21	46

All doctors over 50 years old are more likely to be complained about.

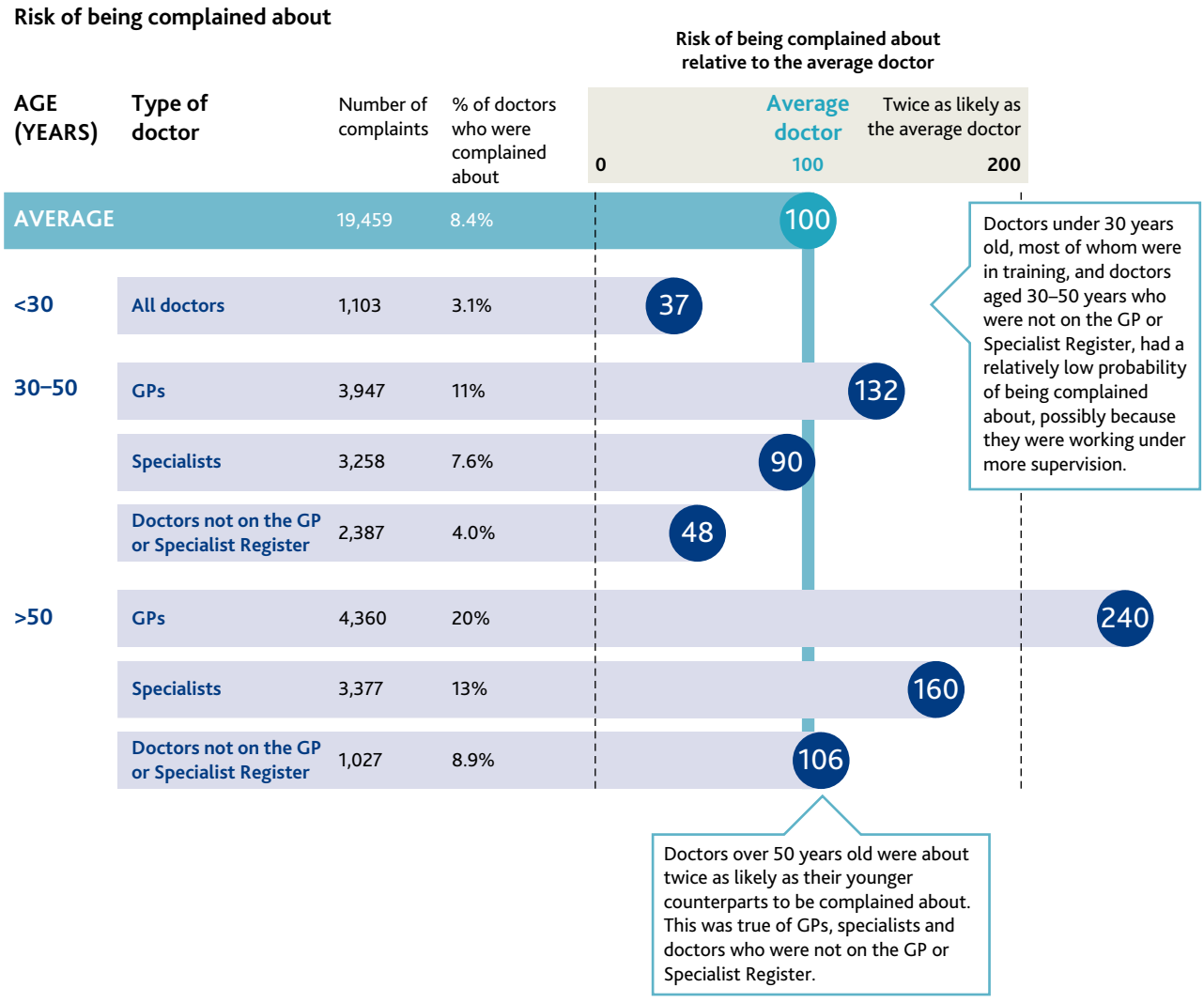
TABLE 5: Number of male and female doctors who were complained about, had the complaint investigated and received a sanction or a warning in 2010–13, by type of doctor and age

Male doctors TYPE OF DOCTOR AND AGE (YEARS)		Number of doctors on the medical register	Number of complaints	Number of complaints investigated	Number of complaints leading to a sanction or a warning			
					Warning	Condition	Undertaking	Suspension or erasure
All doctors	<30	13,824	586	363	59	1	33	17
GPs	30–50	15,446	2,391	846	72	9	40	28
	>50	14,570	3,353	1,250	67	8	65	40
Specialists	30–50	27,369	2,461	951	73	3	40	13
	>50	19,620	2,894	1,159	62	7	36	35
Doctors not on the GP or Specialist Register	30–50	32,999	1,635	1,106	120	7	73	70
	>50	8,076	838	499	20	0	15	44
All doctors		131,903	14,158	6,174	473	35	302	247

Female doctors TYPE OF DOCTOR AND AGE (YEARS)		Number of doctors on the medical register	Number of complaints	Number of complaints investigated	Number of complaints leading to a sanction or a warning			
					Warning	Condition	Undertaking	Suspension or erasure
All doctors	<30	21,419	517	274	21	0	31	6
GPs	30–50	20,157	1,556	434	18	4	25	8
	>50	7,029	1,007	336	15	2	18	4
Specialists	30–50	15,265	797	289	14	1	15	2
	>50	5,519	483	161	12	0	4	0
Doctors not on the GP or Specialist Register	30–50	27,402	752	448	26	3	62	22
	>50	3,502	189	101	4	1	6	2
All doctors		100,292	5,301	2,043	110	11	161	44

Female doctors were less likely to be complained about, have a complaint investigated or receive a sanction or a warning than their male counterparts, for all types of doctor and in all age groups. They were half as likely as male doctors to receive a sanction or a warning.

FIGURE 40: Risk of different types and ages of doctors receiving a complaint, of those complaints being investigated, and of those investigations leading to a sanction or a warning in 2010–13*



* The risk is calculated for a four-year period not per year. The percentages are rounded to one decimal place, but the index for the risk of being complained about, the risk of a complaint being investigated, and the risk of an investigation leading to a sanction or a warning relative to the average doctor is calculated using exact numbers.

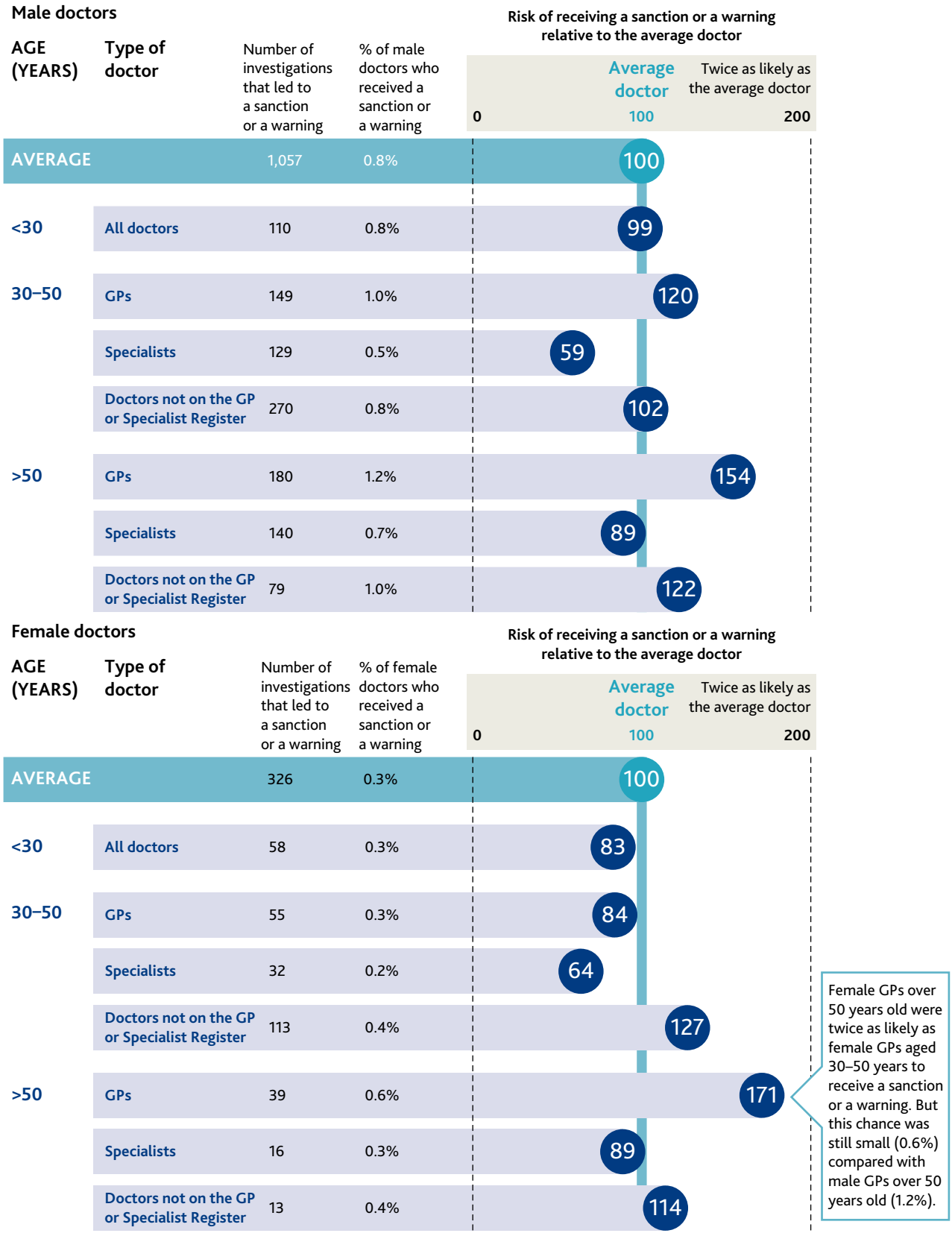
Risk of a complaint being investigated

AGE (YEARS)	Type of doctor	Number of complaints investigated	% of complaints that were investigated	Risk of a complaint being investigated relative to the average doctor (0 – Average doctor 100 – Twice as likely as the average doctor 200)
AVERAGE		8,217	42%	100
<30	All doctors	637	58%	137
30–50	GPs	1,280	32%	77
	Specialists	1,240	38%	90
	Doctors not on the GP or Specialist Register	1,554	65%	154
>50	GPs	1,586	36%	86
	Specialists	1,320	39%	93
	Doctors not on the GP or Specialist Register	600	58%	138

Risk of an investigation leading to a sanction or a warning

AGE (YEARS)	Type of doctor	Number of investigations that led to a sanction or a warning	% of investigations that led to a sanction or a warning	Risk of an investigation leading to a sanction or a warning relative to the average doctor (0 – Average doctor 100 – Twice as likely as the average doctor 200)
AVERAGE		1,383	17%	100
<30	All doctors	168	26%	157
30–50	GPs	204	16%	95
	Specialists	161	13%	77
	Doctors not on the GP or Specialist Register	383	25%	146
>50	GPs	219	14%	82
	Specialists	156	12%	70
	Doctors not on the GP or Specialist Register	92	15%	91

FIGURE 41: Risk of different types and ages of doctors receiving a sanction or a warning in 2010–13*



All doctors

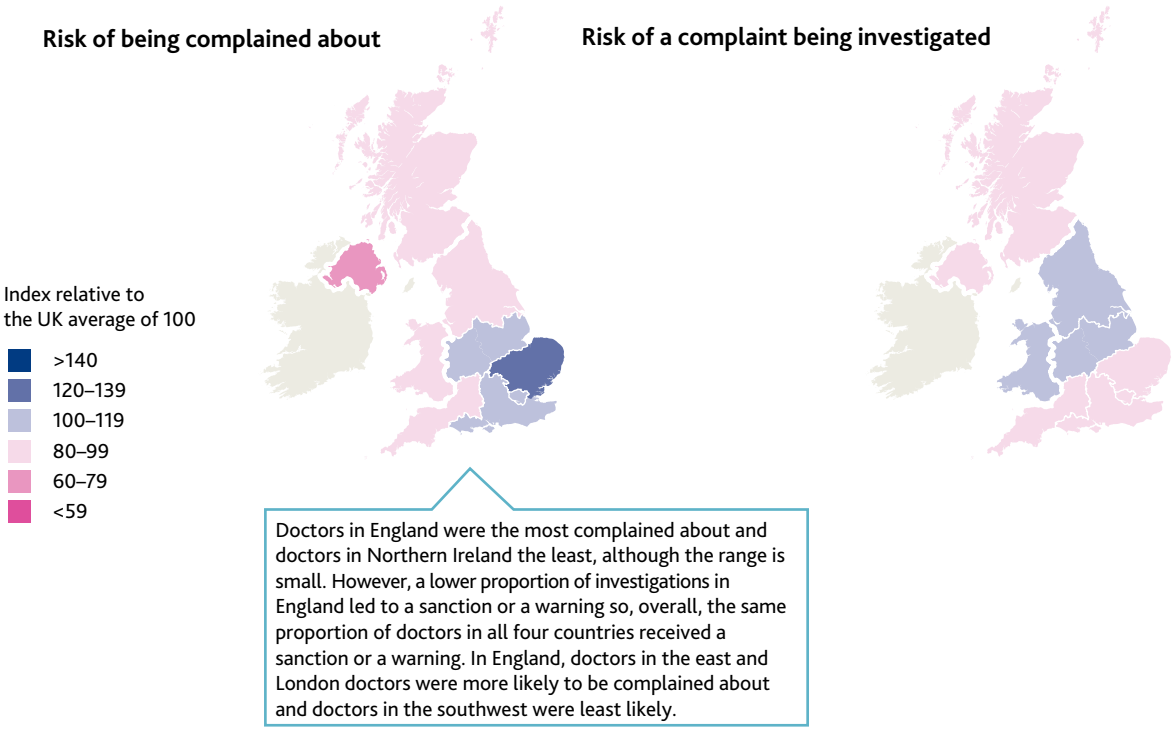
AGE (YEARS)	Type of doctor	Number of investigations that led to a sanction or a warning	% of doctors who received a sanction or a warning	Risk of receiving a sanction or a warning relative to the average doctor
				0 · Average doctor 100 · Twice as likely as the average doctor 200
AVERAGE		1,383	0.6%	100
<30	All doctors	168	0.5%	80
30–50	GPs	204	0.6%	96
	Specialists	161	0.4%	63
	Doctors not on the GP or Specialist Register	383	0.6%	106
>50	GPs	219	1.0%	170
	Specialists	156	0.6%	104
	Doctors not on the GP or Specialist Register	92	0.8%	133

* The risk is calculated for a four-year period not per year. The percentages are rounded to one decimal place, but the index for the risk of receiving a sanction or a warning relative to the average doctor is calculated using exact numbers, based on table 4 (page 72).

English doctors are the most complained about, but doctors in the southwest of England have the lowest risk of receiving a sanction or a warning

FIGURE 42: Doctors being complained about, complaints being investigated, and investigations leading to a sanction or a warning across the UK in 2010–13*

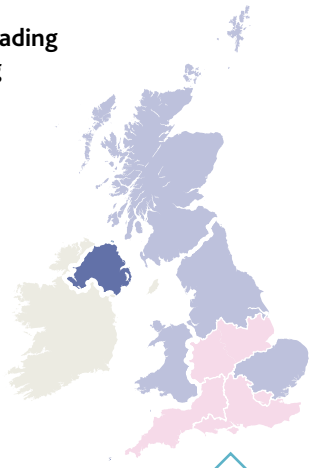
		Risk of being complained about		Risk of a complaint being investigated	
PART OF THE UK	Number of doctors on the medical register	Number of doctors complained about	% of doctors complained about	Number of complaints investigated	% of complaints investigated
North	48,076	3,807	7.9%	1,601	42%
East and West Midlands	28,204	2,431	8.6%	1,026	42%
East	17,498	1,726	9.9%	662	38%
London	38,885	3,695	9.5%	1,393	38%
Southeast	28,160	2,437	8.7%	866	36%
Southwest	14,365	980	6.8%	364	37%
England (total)	175,187	15,076	8.6%	5,912	39%
Northern Ireland	6,000	366	6.1%	134	37%
Scotland	18,816	1,309	7.0%	461	35%
Wales	9,429	676	7.2%	290	43%
UK	209,432	17,427	8.3%	6,797	39%
UK (including doctors with unknown location)	233,474	19,630	8.4%	8,278	42%



Doctors in England were the most complained about and doctors in Northern Ireland the least, although the range is small. However, a lower proportion of investigations in England led to a sanction or a warning so, overall, the same proportion of doctors in all four countries received a sanction or a warning. In England, doctors in the east and London doctors were more likely to be complained about and doctors in the southwest were least likely.

PART OF THE UK	Risk of an investigation leading to a sanction or a warning: Number of investigations that led to a sanction or a warning	% of investigations that led to a sanction or a warning	% of doctors who received a sanction or a warning
North	257	16%	0.5%
East and West Midlands	140	14%	0.5%
East	116	18%	0.7%
London	178	13%	0.5%
Southeast	125	14%	0.4%
Southwest	43	12%	0.3%
England (total)	859	15%	0.5%
Northern Ireland	27	20%	0.5%
Scotland	68	15%	0.4%
Wales	46	16%	0.5%
UK	1,000	15%	0.5%
UK (including doctors with unknown location)	1,388	17%	0.6%

Risk of an investigation leading to a sanction or a warning



In the east, the proportion investigations leading to a sanction or a warning was high, and doctors from there were more likely to end up with a sanction or a warning (0.7%) than doctors from anywhere else. Investigations of doctors from the southwest were least likely to lead to a sanction or a warning. These doctors had the lowest probability overall of receiving a sanction or a warning (0.3%), half the average for the UK.

* The risk is calculated for a four-year period not per year. Excludes doctors with unknown location unless otherwise specified, some of whom had non-UK addresses.

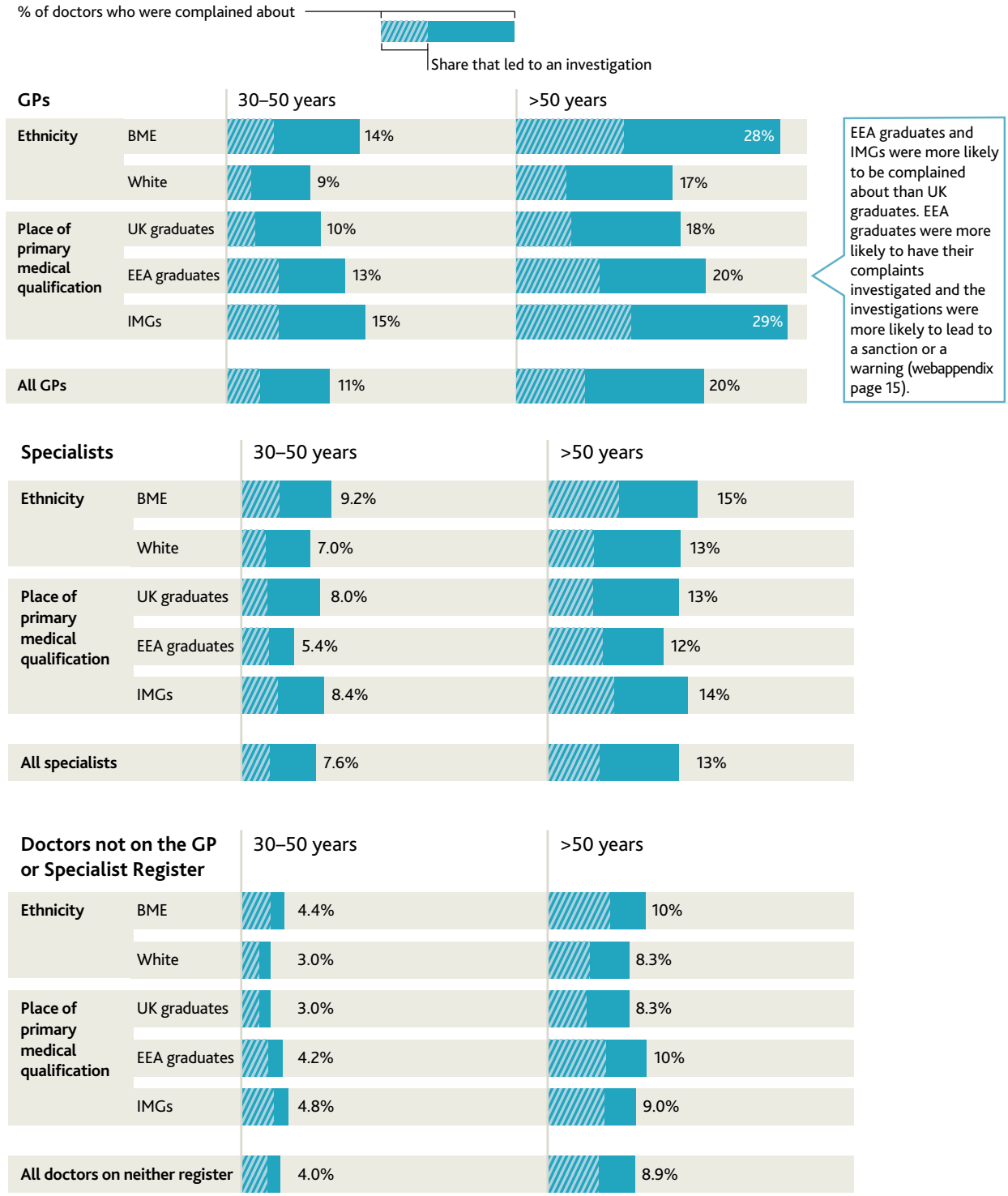
BME doctors were more likely to be complained about than white doctors

BME doctors of all types and ages were more likely to be complained about and to have their complaints investigated than their white counterparts (figure 43). By contrast, a higher proportion of complaints about white doctors are closed before investigation. Webappendix page 15 also shows that investigations about BME doctors were more likely to lead to a sanction or a warning.

Much of the difference between BME and white graduates was associated with the fact that male BME UK graduates were more likely to be complained about and to have their complaints fully investigated (webappendix page 15).

Female BME doctors were more likely to be complained about than their white counterparts, with the exception of doctors over 50 years old who were not on the GP or Specialist Register (webappendix page 15). Female BME UK graduates were more complained about than their white counterparts, but similar proportions of these complaints led to investigations and to sanctions or warnings (webappendix page 15).

FIGURE 43: Risk of different types and ages of doctors being complained about and of those complaints being investigated, by ethnicity and place of primary medical qualification, in 2010–13



Certain specialties are more complained about

FIGURE 44: Risk of specialists being complained about and of those complaints being investigated in 2010–13

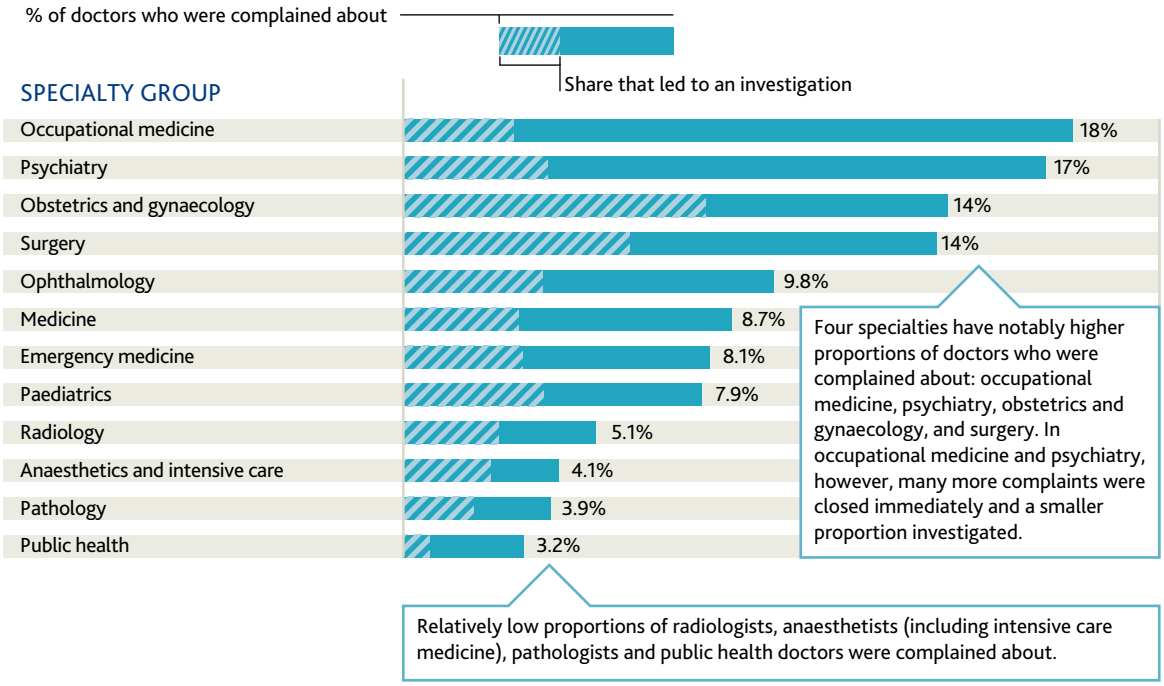
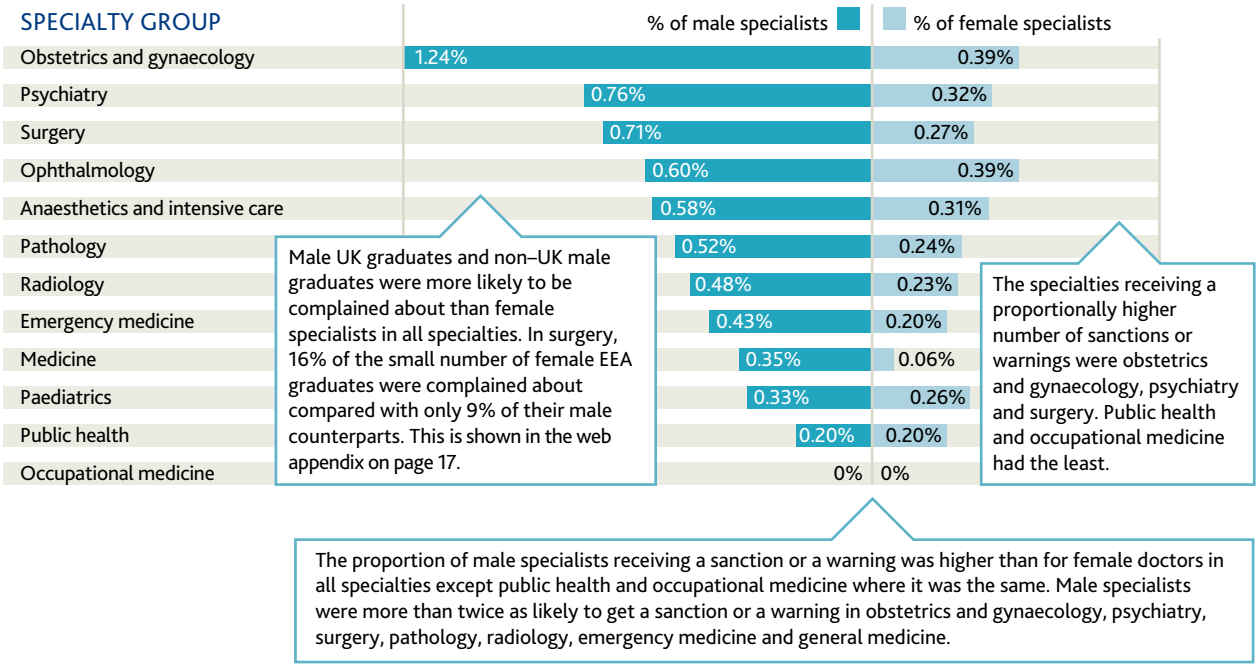


FIGURE 45: Risk of male and female specialists receiving a sanction or a warning in 2010–13



The older a doctor is when joining the register, the greater the probability they will receive a sanction or a warning

The vast majority of UK graduates join the medical register when they are under 30 years old. By contrast, a substantial proportion of non-UK graduates join the register at the ages of 30–40 years old and 40–50 years old. The older a doctor was when they joined the register, the more likely they were to receive a sanction or a warning (figure 46). This is true for both male and female doctors, irrespective of whether they graduated in or outside the UK.

FIGURE 46: Risk of doctors receiving a sanction or a warning in 2010–13, depending on the age at which they joined the medical register and where they graduated

Age when joined register (years)	Place of primary medical qualification	Number of doctors who joined the register		Number of sanctions and warnings received		% of doctors who received a sanction or a warning	
		Male	Female	Male	Female	Male	Female
<30	UK graduates	74,050	68,509	474	162	0.6%	0.2%
	Non-UK graduates	17,770	11,844	154	35	0.9%	0.3%
30–40	UK graduates	3,731	2,758	28	14	0.8%	0.5%
	Non-UK graduates	28,429	13,890	266	87	0.9%	0.6%
40–50*	Non-UK graduates	7,152	3,054	99	20	1.4%	0.7%

Male non-UK graduates joining the register aged 40–50 years had a particularly high chance of receiving a sanction or a warning (1.4%) compared with doctors who joined the register when they were under 30 years old – 0.9% for male non-UK graduates and 0.6% for male UK graduates.

* The number of UK graduates who joined the medical register when they were aged 40 years and over was very small, so we have excluded the data.

Section 13: Multiple complaints made about doctors

There are three elements to multiple complaints – people who make many complaints about the same doctor; people who make several complaints about different doctors; and, from the other side, doctors who are complained about more than once.

FIGURE 47: **Complainants who made one or more complaints during 2010–13**

	Number of complainants	% of complainants
		100%
One complaint	11,734	78%
More than one complaint about more than one doctor	3,020	20%
More than one complaint about one doctor	277	1.8%
Total	15,031	

Only one in 450 complainants made three or more complaints about the same doctor

Over three-quarters of complainants made only one complaint during 2010–13. Of these, the vast majority were about different doctors.

Only 277 of 15,031 complainants (1.8%) made more than one complaint about the same doctor:

- 244 complainants made two complaints
- 27 complainants made three complaints
- Six complainants made more than three complaints.

This means 33 complainants (0.2%) made three or more complaints about the same doctor – about one in 450.

Most doctors have only one complaint made about them

Some doctors have raised concerns about receiving vexatious multiple complaints. Although it is not possible to determine from the data which complaints may be vexatious, the vast majority of doctors who are complained about do not receive multiple complaints from one source.

FIGURE 48: **Doctors who were complained about one or more times during 2010–2013**

Age (years)	Type of doctor	Number of doctors on register	Number of doctors who were complained about	% of doctors who were complained about: One complaint	Two complaints	Three or more complaints
<30	All doctors	35,243	1,225	94%	5.8%	0.7%
>30	GPs	57,202	10,753	81%	14%	4.8%
	Specialists	67,773	7,482	82%	13%	5.0%
	Doctors not on the GP or Specialist Register	71,978	3,888	87%	9.8%	3.5%

Of the 23,348 doctors who were complained about, the vast majority – 83% – had only one complaint made about them. The number of doctors complained about a large number of times was very small:

- 13% (2,951 doctors) were complained about twice
- 4.1% (960 doctors) were complained about between three and five times
- 0.3% (63 doctors) were complained about between six and ten times
- 0.1% (13 doctors) were complained about more than ten times (about one in 2,000 doctors who were complained about).

Most doctors who received multiple complaints will have received them from more than one complainant, rather than from one complainant making multiple complaints.

Chapter 2: Developing our understanding of risk

The evidence in this report shows that the vast majority of doctors do not have complaints made about them that lead to concerns about their fitness to practise. However, we know in the UK and from literature worldwide that a small proportion of doctors do not meet the standards that patients should expect.

In many cases action can be taken at a local level to tackle issues of competence and behaviour. There is also now a revalidation system in the UK for doctor's employers to give the GMC ongoing assurance that all the doctors they employ or contract with are competent and fit to carry out the duties they have been given.

At the same time, it remains important that patients and their relatives, doctors and other healthcare professionals, as well as employers, are able to raise concerns where they believe standards are not being met. In the past, as now, this has enabled us to protect future patients and the reputation of the profession by considering the complaint and, if necessary, investigating and taking action to restrict, suspend or stop the doctor's registration.

By taking a broader look at the nature of these complaints, it should be possible to identify where the risks of poor practice may be greater, and where appropriate action can be taken to mitigate those risks.

In last year's report, we looked at which groups of doctors are most at risk in terms of their age, gender and place of primary medical qualification, and whether they are GPs, specialists or neither. We also considered whether doctors complained about previously – even complaints that were not serious enough to trigger an investigation – were at increased risk of being subject to an investigation at a later date.

In this chapter, we have added data for 2013, data on ethnicity, separated out locums and taken a closer look at specialties. We have also explored why fitness to practise outcomes differ between groups of doctors: are they related to differences in the type of allegations, or to the fact that some cohorts are better able to show insight and demonstrate that they have taken remediatial action?*

* Insight is where the doctor accepts that, with hindsight, they should have behaved differently and will take steps to prevent reoccurrence. Demonstrating remediation involves the doctor taking practical steps to prevent reoccurrence. Doctors who can show insight into what they have done wrong, apologise to the people affected, and remediate the concerns are a lower risk to patients in the future. The independent panel takes these factors into account, in addition to the seriousness and nature of the incident, when deciding the outcome of a case[33] – this is in line with the *Medical Act 1983* as well as the relevant case law.[17]

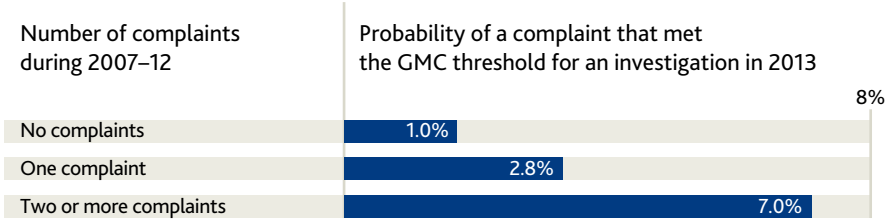
We have pooled data over four years (2010–13) to allow analysis of more than 10,000 complaints. As in the rest of this report, the data cover licensed doctors only. In the last section of this chapter, we explore the role of showing insight or demonstrating remediation in case outcomes by examining 147 panel cases from 2013.

Some groups of doctors are more likely to be complained about or receive sanctions or warnings

Doctors previously complained about

Broadly, our analysis shows that doctors with previous complaints are at greater risk of future complaints – doctors who received two or more complaints during 2007–12 were seven times more likely to receive a complaint that required investigation in 2013 (figure 49).

FIGURE 49: How the pattern of complaints during 2007–12 affected the probability of a doctor being investigated in 2013



Doctors under 30 years old and doctors who are not GPs or specialists

Doctors under 30 years old, most of whom are in training, and doctors not on the GP or Specialist Register aged 30–50 years had a relatively low probability of being complained about (chapter 1, section 12, page 72). This is possibly because they work under more supervision. However, a greater proportion of the complaints about these doctors led to a sanction or a warning than for complaints about GPs and specialists.

Age and gender

The proportion of doctors over 50 years old who were complained about was double that of doctors aged 30–50 years (table 6, page 88). But doctors aged 30–50 years were more likely to receive a sanction or a warning for complaints that we had investigated.

Female doctors were much less likely than their male counterparts to be complained about, investigated and receive a sanction or a warning.

TABLE 6: Doctors in different age and gender groups who were complained about, had the complaint investigated and received a sanction or a warning (2010–13)

GENDER	Male		Female		Total*
AGE (YEARS)	30–50	>50	30–50	>50	
Number of doctors on the medical register	76,165	42,758	63,050	16,258	198,231
Number of doctors who were complained about	6,531	7,164	3,123	1,702	18,520
Number of complaints investigated	2,918	2,942	1,176	605	7,641
Number of investigations that led to a sanction or a warning	550	402	200	68	1,220
% of doctors who were complained about over the four year period	8.6%	17%	5.0%	10%	9.3%
% of complaints investigated	45%	41%	38%	36%	41%
% of investigations that led to a sanction or a warning	19%	14%	17%	11%	16%

* Includes doctors aged 30 years and over and excludes doctors under 30 years old.

Ethnicity and place of primary medical qualification

In table 7, we look at how black and minority ethnic (BME)* doctors and white doctors progress through the fitness to practise process, controlling for whether doctors are UK graduates, European Economic Area (EEA) graduates,† or international medical graduates (IMGs),‡ and whether they are on the GP or Specialist Register. Taking this into account, BME doctors were more often complained about than white doctors, the only exception being IMGs on neither the GP nor Specialist Register. For those with complaints against them, BME doctors were more likely to face investigation by the GMC than their white counterparts, and of these, a higher proportion of BME doctors received a sanction or a warning except for EEA graduates who were on the GP Register and IMGs on the Specialist Register.

Among UK graduates, BME doctors are roughly 30% more likely to receive a sanction or a warning. Most IMGs are BME and they are 39% more likely than white UK graduates to receive a sanction or a warning. It should be noted that the small group of white IMGs are also 27% more likely than white UK graduates to receive a sanction or a warning.§

Specific groups more likely to receive a sanction or a warning

Figures 50 and 51 (page 90) show variation in the proportions who received a sanction or a warning across place of primary medical qualification and ethnicity for doctors over 50 years old and GPs aged 30–50 years, particularly for male doctors. All groups of male over 50s except for white UK graduates are above the 0.6% average for all doctors.

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

† 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.

§ We do not know the ethnicity of some doctors, but our analysis (see box 2, page 42) suggests that this is unlikely to distort findings on ethnicity.

Our findings resonate with reports by other healthcare organisations. For example, BME staff are almost twice as likely as white staff to be involved in NHS disciplinary proceedings.[18] And these challenges are not restricted to healthcare – BME solicitors are at a higher risk of being investigated and receiving a sanction than white solicitors.[19]

We commissioned independent research from NatCen, which showed that confidence in our ability to regulate the medical profession was generally high among all doctors.[15] We have a rolling programme of work to ensure the consistency and fairness of our investigations and processes, which will published as they are completed. We strive to eliminate discrimination and actively promote equality in all our processes.

TABLE 7: Doctors with different ethnicity and place of primary medical qualification who were complained about, had the complaint investigated and received a sanction or a warning (2010–13)*

PLACE OF PMQ / ETHNICITY	UK graduates		EEA graduates		IMGs		Total†
	BME	White	BME	White	BME	White	
Doctors on the GP Register							
Number of doctors on the medical register	4,610	28,918	301	21,76	6,688	755	43,448
% of doctors who were complained about over the four year period	16%	12%	22%	14%	21%	18%	14%
% of doctors with a complaint investigated	34%	29%	52%	42%	39%	38%	33%
% of investigations that led to a sanction or a warning	15%	12%	21%	23%	15%	13%	14%
% of doctors that received a sanction or warning over the four year period	0.8%	0.4%	2.3%	1.4%	1.3%	0.9%	0.7%
Doctors on the Specialist Register							
Number of doctors on the medical register	4,871	30,777	532	7,279	11,583	2,363	57,405
% of doctors who were complained about over the four year period	12%	10%	10%	7.2%	11%	11%	10%
% of doctors with a complaint investigated	38%	32%	53%	47%	47%	38%	38%
% of investigations that led to a sanction or a warning	13%	10%	17%	15%	13%	14%	12%
% of doctors that received a sanction or warning over the four year period	0.6%	0.3%	0.9%	0.5%	0.7%	0.6%	0.5%
Doctors not on the GP or Specialist Register							
Number of doctors on the medical register	6,314	18,775	864	4,802	21,188	2,942	54,884
% of doctors who were complained about over the four year period	3.5%	3.3%	9.4%	4.1%	5.6%	6.2%	4.5%
% of doctors with a complaint investigated	62%	55%	69%	63%	66%	62%	62%
% of investigations that led to a sanction or a warning	24%	19%	30%	22%	21%	18%	21%
% of doctors that received a sanction or warning over the four year period	0.5%	0.3%	2.0%	0.6%	0.8%	0.7%	0.6%

* Excludes those aged under 30 years.
† Includes doctors of BME or white ethnicity, and excludes doctors of unknown ethnicity.

PMQ = primary medical qualification

FIGURE 50: Proportion of doctors over 50 years old who received a sanction or a warning (2010–13) *,†

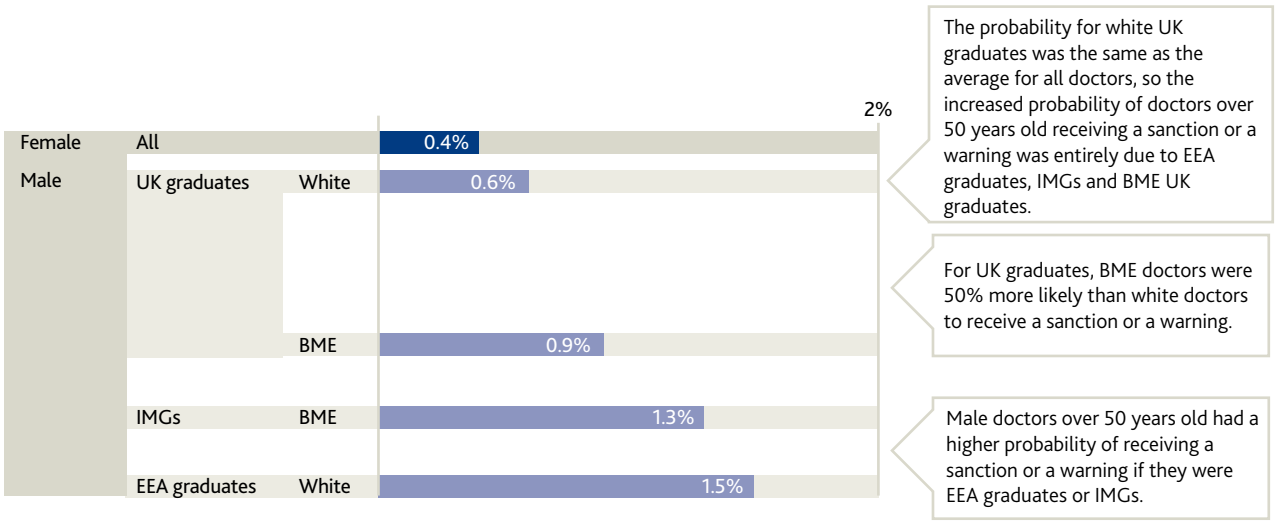
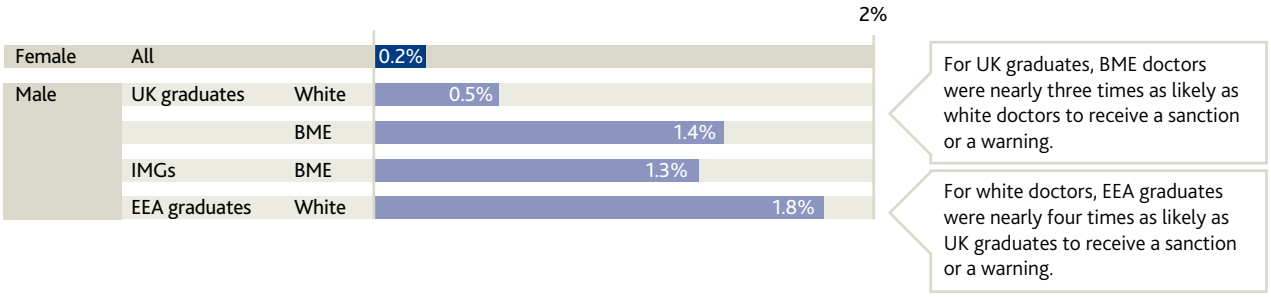


FIGURE 51: Proportion of GPs aged 30–50 years who received a sanction or a warning (2010–13) *,†



* Almost all EEA graduates are white and almost all IMGs are BME, so we have excluded EEA graduates who are BME and IMGs who are white from these charts. These excluded groups do have higher proportions of doctors receiving sanctions and warnings than their counterparts for most groups by gender and place of primary medical qualification.

† The overall probability for female doctors is given for comparison. Because female doctors receive far fewer sanctions and warnings than male doctors, sample sizes by gender and place of primary medical qualification are small. But, similar to male doctors, white EEA graduates and BME IMGs who are female both have a higher proportion of sanctions and warnings than female UK graduates from each of the ethnic groups. Even for these groups of female doctors, however, the overall probability of receiving a sanction or a warning is close to the average for all doctors.

Locums

Locum doctors are employed across the UK to meet fluctuations in activity levels and to cover vacancies, short-term absences, and sickness and study leave of medical staff. Looking at spending figures,[20, 21, 22, 23] use of locums seems to be increasing across the UK. Properly managed, locums can play an important role in helping hospitals achieve flexibility.[23]

Our data show that doctors attached to a locum agency were a little more likely to be complained about, and more likely to have those complaints investigated. Locum doctors were also more likely to result in a sanction or a warning (table 8). We are keen to understand more about the reasons behind the higher risks from locum doctors and how these can be mitigated.

TABLE 8: Doctors over 30 years old, who were not in training, who were complained about, had the complaint investigated and received a sanction or a warning, by whether they were attached to a 'secondary care' locum agency (2010–13)*

COMPLAINTS, INVESTIGATIONS AND OUTCOMES	GPs		Specialists		Doctors not on the GP or Specialist Register		Total	
	Not locum	Locum	Not locum	Locum	Not locum	Locum	Not locum	Locum
Number of doctors on the medical register	58,070	56	70,223	1,229	67,255	3,035	195,548	4,320
% of doctors who were complained about over the four year period	14%	21%	9.2%	11%	4.7%	8.7%	9.2%	9.6%
% of complaints investigated	34%	75%	38%	63%	62%	75%	41%	71%
% of investigations that led to a sanction or a warning	17%	33%	15%	10%	28%	16%	19%	15%
% of doctors on the medical register who received a sanction or a warning over the four year period	0.7%	3.6%	0.4%	0.6%	0.7%	0.9%	0.6%	0.8%

* These data are based on the doctors who have attached to a secondary care locum agency as their designated body for revalidation in 2013. This means we do not have a complete picture because some locums will have connected to the employer who has employed them most in the recent past, rather than to a locum agency. In some cases, doctors not working exclusively as locums would be connected to their other employer and not to a locum agency. Also, we have pooled data for 2010–13, which means that some doctors now connected to a locum agency may not have been a locum throughout those four years. And, as we only began to record connections to designated bodies in 2013, our data do not include any doctors erased from the register during 2010–12 – for this reason, we have not shown data for different types of sanction, such as erasure. We have not included data for internal locums – ie those working extra shifts for their existing employer. We have excluded doctors who are on both the GP and Specialist Registers due to low sample sizes, and excluded doctors who have been erased, as only recently erased doctors would have had a designated body (locum or non-locum) assigned.

Variation in risk across specialties

The average risk of being complained about or receiving a sanction or a warning varies between specialty groups (table 9).

As we have seen, male doctors, doctors over 50 years old, and non-UK graduates tend to be at higher risk of being complained about and receiving a sanction or a warning. However, there appears to be little correlation between the proportion of different groups of doctors in a specialty and the probability of doctors in that specialty being complained about or receiving sanction or a warning. In other words, the specialty itself appears to carry risk and is not a reflection of the type of doctors who work in it.

Doctors in three specialty groups were particularly likely to be complained about or receive a sanction or a warning – psychiatry, obstetrics and gynaecology, and surgery. They all had a slightly higher proportion of doctors over 50 years old than most other specialty groups. Psychiatry and obstetrics and gynaecology also had slightly higher proportions of non-UK graduates, and surgery had a much higher proportion of male doctors. However, the scattered percentages in the last three columns of table 9 suggest there is little correlation between the presence of these cohorts and the risk of doctors within a specialty being more complained about or receiving more sanctions or warnings. A separate analysis of sanctions across specialties for doctors of different ages, and for UK and non-UK graduates, found that the ranking of the specialties by the proportion of complaints and by the proportion of sanctions or warnings did not differ substantially.

All this suggests that differences in the proportion of doctors being complained about or receiving a sanction or a warning are related much more to the nature of the specialties than the demographic characteristics of doctors working in them.

Surgery, where outcomes are often more clear-cut, is one of the top three specialty groups for doctors being complained about and receiving a sanction or a warning. In particular, there have been serious concerns about practices within cosmetic surgery (box 3, page 94). The GMC is currently working together with the surgical royal colleges and the Department of Health in England, among others, on these issues.[24]

TABLE 9: Demographic characteristics of doctors on the Specialist Register, ranked in different specialty groups, and ranked according to the proportion who were complained about (2010–13)*

SPECIALTY GROUP	Number of doctors	% of doctors who were complained about	% of doctors who received a sanction or a warning	% of male doctors	% of doctors over 50 years old	% of non-UK graduates
Psychiatry	7,899	17%	0.6%	60%	39%	43%
Obstetrics and gynaecology	3,541	14%	0.9%	57%	41%	53%
Surgery	12,335	14%	0.7%	91%	39%	41%
Ophthalmology	2,015	9.8%	0.5%	75%	38%	47%
Medicine	16,484	8.7%	0.3%	69%	36%	32%
Emergency medicine	1,664	8.1%	0.4%	71%	24%	25%
Paediatrics	4,752	7.9%	0.3%	51%	35%	45%
Radiology	5,105	5.1%	0.4%	65%	34%	33%
Anaesthetics and intensive care medicine	9,267	4.1%	0.5%	69%	32%	38%
Pathology	2,980	3.9%	0.4%	58%	46%	42%

Nearly one in five **psychiatrists** were complained about in 2010–13, compared with just one in 25 pathologists or anaesthetists.

Psychiatry, **obstetrics and gynaecology**, and **surgery** stand out as having the highest proportion of doctors who were complained about and received a sanction or a warning.

* We excluded data for occupational medicine and public health because too few complaints were received in these specialties for the findings to be robust. We also excluded 254 doctors with old specialties that do not fit into the 12 defined specialty groups.

BOX 3: Growing concerns about cosmetic surgery

Cosmetic surgery is an industry that was worth £2.3 billion in 2010 and is estimated to rise to £3.6 billion by 2015.[25] It frequently hits the headlines[26] for operations and procedures going wrong, and a scandal over breast implants attracted widespread attention and government action.[27, 28]

In 2013, a major review by Sir Bruce Keogh found a concerning lack of data about cosmetic surgery and patient outcomes.[25] To understand this area of practice better, we have begun by looking at whether the 799 plastic surgeons on our Specialist Register between 2010 and 2013 are at higher risk than other surgeons (table 10).* Unfortunately it has not been possible to separate those undertaking purely cosmetic procedures from, for example, the plastic surgeons treating burns and scars caused by trauma or surgery. Nevertheless it is clear that plastic surgeons do have a higher risk of receiving complaints, being investigated and receiving a sanction or a warning.

During 2010–13, there were 85 investigations about plastic surgeons:

- 36 involved criminality, or falling to act honestly and fairly
- 27 involved clinical competence
- eight involved issues in both the groups above
- 14 were about health or other issues.

Regulation of cosmetic interventions

Non-surgical procedures, such as facial fillers to reduce wrinkles and Botox injections, are often carried out by doctors and nurses, but have been done by people who are not medically or nursing qualified. These non-surgical procedures account for nine out of ten procedures and 75% of the market value.[25]

The GMC[29] and the Nursing and Midwifery Council[30] clearly set out the standards expected of doctors and nurses. However, both doctors and nurses have some freedom to carry out cosmetic procedures. For example, surgeons specialising in one part of the body can carry out cosmetic surgery on any other part.

The key point here is that no doctor should be undertaking any procedure for which they are not properly trained and experienced.[31] And the data above do not capture the concerns raised about doctors who are not plastic surgeons.

The Department of Health in England is now considering whether to implement the Keogh review's recommendation that only doctors on the GMC's Specialist Register should perform cosmetic surgery in their areas of specialty to make sure patients are protected, and that doctors have the training and skills needed to undertake cosmetic surgery.[25] The GMC is also working with the Royal College of Surgeons and others to explore whether further qualifications can be developed to recognise those with appropriate expertise in this area and if there is further specific guidance that doctors need.

* Cosmetics procedures may be offered by surgeons qualified in other specialties, but plastic surgeons are particularly likely to offer cosmetic procedures.

TABLE 10: Risk of plastic surgeons being complained about, having the complaint investigated and receiving a sanction or a warning

COMPLAINTS, INVESTIGATIONS AND OUTCOMES	Plastic surgeons	Surgeons	All specialty groups*
Number of doctors on the medical register	799	49,339	67,782
Number of doctors who were complained about	115	1,735	6,636
Number of complaints investigated	85	738	2,560
Number of investigations that led to a sanction or a warning	12	82	314
% of doctors who were complained about over the four period	14%	3.5%	9.8%
% of doctors who had a complaint investigated over the four period	11%	1.5%	3.8%
% of doctors who received a sanction or a warning over the four period	1.5%	0.2%	0.5%

Plastic surgeons were four times more likely to be complained about than other surgeons.

Plastic surgeons were seven times more likely to have a complaint investigated and to receive a sanction or a warning than other surgeons.

* We excluded 254 doctors with old specialties that do not fit into the 12 defined specialty groups.

Are some cohorts of doctors more likely to receive a sanction or a warning because they are prone to particular types of allegation?

The outcome of any fitness to practise case depends on the seriousness of the allegation and whether the doctor can demonstrate insight and that they can remediate the concern. Despite this, certain allegations – such as those involving a doctor's health or that are linked to criminality – are more likely to result in a sanction or a warning.

Here we examine whether particular cohorts of doctors are more likely to have certain types of allegation made about them, and what the source of the complaint is. We then look at which cohorts of doctors receive the types of allegation that are more likely to lead to a sanction or a warning.

We use here the broad allegation types introduced in chapter one and summarised in box 4 (page 96). It is important to understand the definitions we have used when interpreting our findings, and that the allegation types do not capture the severity of the allegation, only the nature of each case.

Categorising cases by the allegations they raise

Many cases raise more than one of the types of allegation shown in box 4. So we have defined seven categories of cases. Each category is a particular combination of allegations, as shown in table 11. Each case fits into only one category. It is important to note that the categories are arranged in a hierarchy – if a case contains a particular type of allegation, such as clinical competence, it is only placed in the clinical competence category if the other allegations involved in the case have not caused it to be placed in a category higher up the hierarchy.

As the combination of allegations in each of the seven categories has a similar chance of the investigation leading to a sanction or a warning, it is possible to see if the categories of allegations involved in the cases are part of the reason for some groups of doctors being more likely to receive a sanction or a warning than others.

Table 11 shows there was a reasonably large number of cases in each category during 2010–13, which helps make the findings more robust.

BOX 4: Types of allegation

Health: substance misuse, mental and behavioural issues, and other health issues affecting judgement.

Criminality: violence, sexual issues, harassment, motoring offences, fraud, and other criminal activities.

Acting honestly and fairly: failure to act with honesty and integrity, treating or prescribing for themselves or friends, and unfairness or discrimination.

Professional performance: failure to follow guidance, codes or regulations, inadequate training and knowledge, inadequate leadership, poor record keeping, and inefficient use of resources.

Clinical competence: bad judgement of own abilities, poor diagnosis and examination, prescribing problems, and other clinical issues.

Communication and respect for patients: lack of appropriate communication, failure to coordinate care, and lack of respect for patients.

Working with colleagues: not meeting teaching or training responsibilities, and not working well with colleagues.

Safety and quality systems: inadequate use of safety and quality systems, inadequate response to risks, and delay or failure to raise concerns.

TABLE 11: Categories of cases investigated by the GMC in 2010–13

CATEGORIES OF ALLEGATION	Number of cases	Number of sanctions and warnings received	% of cases leading to a sanction or a warning
1 All health	**865**	**405**	**47%**
2 Other criminality	**1,067**	**397**	**37%**
2a Only criminality	679	228	34%
2b Criminality, acting honestly and fairly	306	147	48%
2c All other criminality	82	22	27%
3 Other acting honestly and fairly	**2,403**	**320**	**13%**
3a Only acting honestly and fairly	1130	156	14%
3b Acting honestly and fairly, clinical competence	272	35	13%
3c Acting honestly and fairly, clinical competence, communication and respect for patients	125	12	10%
3d Acting honestly and fairly, clinical competence, professional performance	99	17	17%
3e All other acting honestly and fairly	777	100	13%
4 Other professional performance	**1,367**	**180**	**13%**
4a Only professional performance	359	49	14%
4b Professional performance, clinical competence	425	57	13%
4c Professional performance, clinical competence, communication and respect for patients	298	40	13%
4d All other professional performance	285	34	12%
5 Other clinical competence	**2,576**	**108**	**4.2%**
5a Only clinical competence	1,681	73	4.3%
5b Clinical competence, communication and respect for patients	715	20	2.8%
5c All other clinical competence	180	15	8.3%
6 Other communication and respect for patients	**333**	**33**	**10%**
6a Only communication and respect for patients	289	28	10%
6b All other communication and respect for patients	44	5	11%
7 Other working with colleagues and safety and quality systems	**206**	**9**	**4.4%**
7a Only working with colleagues	133	7	5.3%
7b Only safety and quality systems	66	2	3.0%
7c Working with colleagues, safety and quality systems	7	0	0.0%

This type of allegation includes all cases that had an allegation about health, irrespective of whether the case also raised other types of allegation.

This type of allegation includes all cases that had an allegation about criminality, without an allegation about health. This is because cases involving an allegation about health are already covered higher in the hierarchy.

We have separated out cases that raised only one type of allegation, and cases that raised a combination of allegations where there were enough cases to make the analysis robust.

There are many cases with allegations about clinical competence, but most are included in the types of allegation higher in the hierarchy. Cases with these combinations of allegations have a significantly higher probability of leading to a sanction or a warning.

By contrast, 5% or fewer cases end in a sanction or a warning when they have allegations about clinical competence only, or combined with allegations about communication and respect for patients, working with colleagues, or safety and quality systems.

Are higher-risk cohorts of doctors more likely to have certain types of allegation against them ?

As we have seen, higher proportions of male doctors, non-UK graduates, BME doctors and doctors aged 30–50 years tend to be investigated and have their investigation lead to a sanction or a warning. We have looked at the cases involving these groups to see if this is because they have higher volumes of cases with particular allegations that have a higher chance of leading to a sanction or a warning (notably cases involving health or criminality).

- **Health cases:** there are no substantial differences in the proportion of these cases among doctors from different cohorts.
- **Other criminality cases:** nearly double the proportion of BME doctors' cases are in this category compared with white doctors (9.1% versus 5.2%), and a substantially higher proportion of male doctors' cases than female doctors (8.1% versus 4.8%). Also, a higher proportion of non-UK graduates' cases than UK graduates are of this category (EEA 7.0%, IMG 9.6% versus 5.9% for UK), and more than double for doctors aged 30–50 years than for doctors over 50 years old (10% versus 4.3%). This suggests that for these groups of doctors having cases involving other criminality is part of the reasons for them having a greater chance of receiving a sanction or a warning.
- **Other professional performance cases:** 14% of UK graduates' cases are in this category, compared with 18% of IMGs' cases and 21% of EEA graduates' cases.
- **Other communication and respect for patients cases:** 9.4% of UK graduates' cases are in this category, compared with 7.3% of EEA graduates' cases and 7.9% of IMGs' cases. White female EEA graduates have the highest percentage at 11%.

Source of complaints

Nearly six times as many cases were from the public than were from employers, as shown in table 12. The cases most likely to lead to a sanction or a warning (health and criminality) accounted for only 1.7% of cases from the public, but 24% of those from employers. Clinical competence accounted for over half of cases from the public (55%), but only 14% from employers. This partly explains, as we showed in last year's report,[32] why complaints from employers have a significantly higher chance than those from the public of being investigated and leading to a sanction or a warning. But it is also because employers are more likely to have a clear view of the context of any complaint or incident and to have a view of the doctor's whole practice.

The low proportion of clinical competence cases leading to an investigation or a sanction or a warning is partly due to the high number of complaints from the public about clinical issues that do not lead to a sanction or a warning.

There are two interesting findings about the cohorts of doctors involved in the cases that originated from employers' complaints.

TABLE 12: Types of allegation from the public and from employers

TYPES OF ALLEGATION	Complaints originating from the public (6,925 cases)	Complaints originating from employers (1,234 cases)
Health	1.1% (76)	18% (224)
Criminality	0.6% (44)	5.5% (68)
Acting honestly and fairly	19% (1,316)	33% (409)
Professional performance	14% (946)	20% (248)
Clinical competence	55% (3,775)	14% (177)
Communication and respect for patients	10% (710)	5.3% (66)
Working with colleagues, and safety and quality systems	0.8% (58)	3.4% (42)

First, in relation to cases from employers involving health allegations:

- almost a quarter (24%) of white doctors' cases were related to health allegations compared with 13% of BME doctors' cases
- a high proportion of UK graduates' cases were related to health compared with non-UK graduates' cases (26% versus 13%)
- a higher proportion of investigations of female doctors involved health than those for male doctors (25% versus 16%).

Second, in relation to cases from employers relating to criminality allegations (excluding those also linked to health):

- a higher proportion of BME doctors' cases were related to criminality allegations than those for white doctors (7.6% versus 3.2%)
- a higher proportion of IMGs' cases (most of IMGs are BME doctors) were related to criminality allegations than those for UK or EEA graduates (8.1% versus 3.5% and 2.2% respectively).

Broadly, our analysis shows that a relatively high proportion of IMGs' and BME doctors' cases are about criminal allegations, many of which originate from employers' complaints. By contrast, a high proportion of white UK graduates' cases are about clinical competence allegations. These tend to be from the public and have a lower probability of leading to a sanction or a warning.

The chances of an investigation leading to a sanction or a warning

We have shown above that different cohorts of doctors have different categories of allegations involved in their cases, and that this in part explains why some cohorts have a higher probability of receiving a sanction or a warning. But there is an additional factor because, for some groups, the chances of an investigation leading to a sanction or a warning is higher even after controlling for the categories of allegations those groups receive – ie even when considering each category of case separately.

This is shown in figure 52. Male doctors, BME doctors, non-UK graduates, and doctors aged 30–50 years are all at higher risk of a sanction or a warning for some categories of case.

FIGURE 52: Risk of investigation leading to a sanction or a warning for various cohorts of doctors

Difference in risk of a sanction or a warning between groups:

Much more likely | More likely | Little difference* | Less likely | Much less likely

CATEGORIES OF CASE (overall likelihood)	Gender		Ethnicity		Place of primary medical qualification			Age (years)	
	Male	Female	BME	White	UK graduates	EEA graduates	IMGs	30–50	>50
Health (47%)	Male less likely (44% vs 52%)		No difference		IMGs much less likely (36% vs 50% for UK and EEA graduates)			30–50 years much more likely (55% vs 36%)	
Criminality (39%)	Male much more likely (42% vs 26%)		Little difference (39% for BME vs 35% for white)		Little difference (41% for IMGs vs 38% for UK and EEA graduates)			Little difference (40% for 30–50 years vs 37% for >50 years)	
Acting honestly and fairly (15%)	No difference		BME more likely (18% vs 12%)		Non-UK more likely (20% vs 10%)			30–50 years more likely (17% vs 13%)	
Professional performance (15%)	Male more likely (16% vs 11%)		No difference		Non-UK more likely (18% vs 11%)			Little difference (17% for 30–50 years vs 13% for >50 years)	
Clinical competence (5%)	No difference		No difference		Non-UK more likely (7% vs 3%)			No difference	
Communication and respect for patients (12%)†	Little difference (12% for male vs 9% for female)		Little difference (18% for BME vs 10% for white)		Little difference (15% for non-UK graduates vs 10% for UK graduates)			Little difference (13% for 30–50 years vs 10% for >50 years)	

Female doctors were more likely to receive a sanction or a warning if the allegation was about health. Whereas male doctors were far more likely to receive a sanction or a warning if the allegation was about criminality, or, to a lesser extent, if the allegation was about professional performance.

BME doctors were more likely to receive a sanction or a warning than white doctors if the allegation was about acting honestly and fairly.

Non-UK graduates were more likely to receive a sanction or a warning than UK graduates if the allegation was about anything other than health, although there was less of a difference for criminality allegations and communication and respect for patients. By contrast, for health allegations, IMGs were less likely to receive a sanction or a warning than UK and EEA graduates.

Although doctors over 50 years old were at higher risk of receiving a sanction or a warning than younger doctors, when we look at each type of allegation they actually became less likely than younger doctors to receive a sanction or a warning from an investigation. This shows that the higher proportion of doctors over 50 years old who received a sanction or a warning was mainly because these doctors were both more likely to be complained about, and also were more likely to get the types of allegation that resulted in a sanction or warning overall even though, for each allegation, they were less likely to receive a sanction or a warning than younger doctors.

* The difference is not statistically significant at the 5% level.

† We excluded data for working with colleagues and safety and quality systems because the sample size was too small.

Are some cohorts of doctors at higher risk because they are less able to offer insight, apologise and remediate the concerns?

The role of insight, apology and remediation in deciding the outcome of cases

In the most serious cases, we refer doctors to a fitness to practise panel hearing of the Medical Practitioners Tribunal Service (MPTS). The GMC and the doctor, or the doctor's representative, present evidence in relation to the allegations, and the MPTS makes an independent decision on whether the doctor's practice is impaired and, if so, what sanction or warning to give. This decision is based on whether the doctor presents a risk to:

- patients in the future
- the reputation of the medical profession that would undermine public confidence.

The panel decision is not intended to be punitive for past wrongs. Instead it aims to protect patients, maintain public confidence in doctors, and declare and uphold proper standards of conduct and behaviour. A panel consists of at least one medical and one non-medical person appointed through open competition.

As is made clear in the GMC's core guidance, *Good medical practice,*[31] doctors who can show insight into what they have done wrong, apologise to the people affected, and remediate the concerns are a lower risk to patients in the future. The independent panel takes these factors into account, in addition to the seriousness and nature of the incident, when deciding the outcome of a case[33] – this is in line with the *Medical Act 1983* as well as relevant case law. For certain allegations, such as sexual misconduct, it is more difficult to show that future patients are not at risk, so a high proportion results in erasure. But other allegations have more opportunities for remediation and therefore a higher chance of avoiding the most serious sanction.

In Paula Case's study into fitness to practise and the concept of impairment, this redemptive style of resolving matters is found to encourage doctors to reflect and learn, and to express remorse and contrition.[34] This can benefit both the doctor, as they demonstrate that they are improving what they do, and the patient, who may be a witness in the case. However, Paula Case also points out that incentivising remorse and contrition might result in doctors individualising the blame for an incident, thus obscuring more structural problems that may have led to their impaired practice. The study also speculates that some cases of remorse might be insincere and that the doctor might not have actually learnt from their experience.

To investigate the role of insight, apology and remediation, we have exammed the 147 cases heard at MPTS Panels in 2013 that related to conduct and performance.

Cases included in our analysis

In 2013, 258 cases were referred for a panel hearing. We excluded cases involving a conviction or allegations about a doctor's health,* and analysed the panel judgments on the remaining 147 doctors' cases that closed in 2013. These cases resulted in:

- 34 doctors erased from the medical register
- 48 doctors suspended from the medical register
- 18 doctors having conditions imposed on their registration
- four doctors being voluntarily erased from the medical register
- one doctor being seeing as impaired, but no action being taken
- 42 doctors being seeing as not impaired

Two-thirds of the cases cover three broad areas: poor diagnosis and examination; honesty, fraud and fairness; and criminality. We have divided the remaining third into high, medium and low in terms of risk of that allegation type receiving a high severity sanction. The outcomes for each type of case is shown in table 13.

The findings of our analysis should be interpreted with caution because each case is unique, so it is difficult to clearly categorise outcomes and behaviours, and the broad groupings do not capture the severity of the allegations. Also, the sample size is too small for some findings to be statistically significant, meaning that some relationships may exist but not be evident. Analysis by gender has not been undertaken due to the low number of female doctors (23) involved in panel hearings in 2013.

TABLE 13: Outcomes for different types of case

TYPE OF CASE	Number of cases	Erasure	Suspension	Conditions	Other sanction
Poor diagnosis and examination	39	9	7	12	11
Honesty, fraud and fairness	46	9	19	0	18
Criminality†	30	7	12	1	10
Other high risk	15	7	3	4	1
Other medium risk	11	2	5	1	3
Other low risk	4	0	0	0	4
Unknown or not categorised	2	0	2	0	0
Total	**147**	**34**	**48**	**18**	**47**

† Only cases where the doctor did not go to court, or was aquitted, are included here.

* We excluded these cases because the panel does not reconsider facts already ruled on by a court, which would happen in cases involving a conviction, and hearings involving allegations about a doctor's health are held in private and the details are confidential.

Ethnicity and place of primary medical qualification of doctors at panel hearings

Table 14 (page 104) shows the types of case that different cohorts of doctors face at panel hearings. The cases involving BME doctors were broadly in line with our earlier findings on the types of allegation they face – proportionately more allegations about criminality (22% compared with 14% for white doctors).

White doctors had a higher proportion of panel cases about poor diagnosis and examination. These types of allegation are, in the overall complaints process, less likely to result in the doctor being erased or suspended from the medical register than cases about criminality (41% versus 62%). This suggests that the types of case involving white doctors may be one of the most important factors in a lower proportion of them being suspended or erased than BME doctors.

The proportion of erasures and suspensions of EEA graduates is higher than the case mix would suggest.

Far fewer UK graduates were erased than suspended (five erased compared with 19 suspended), whereas equal numbers of non-UK graduates were erased and suspended (29 for each outcome). This may in part be explained by UK graduates showing insight more clearly or having less severe cases.

UK graduates' cases were more likely to be about honesty, fraud and fairness than IMGs' or EEA graduates' cases (12 out of 30 cases compared with four out of 12 for EEA graduates and 11 out of 46 for IMGs), as shown in table 14 (page 104). IMGs were more often involved in cases about criminality than UK or EEA graduates (13 out of 46 cases compared with four out of 30 for UK graduates and one out of 12 cases for EEA graduates).

TABLE 14: Types of case and their outcomes by the doctors' place of primary medical qualification and ethnicity

	Number of cases*	UK graduates		EEA graduates	IMGs
TYPE OF CASE		BME	White	White	BME
Poor diagnosis and examination	39	0	8	5	12
Honesty, fraud and fairness	46	8	4	4	11
Criminality	30	1	3	1	13
Other high risk	15	0	1	1	5
Other medium risk	11	2	1	0	3
Other low risk	4	1	0	0	2
Unknown or not categorised	2	0	1	1	0
Total	**147**	**12**	**18**	**12**	**46**
OUTCOMES					
Erasure	34	1	2	4	11
Suspension	48	5	7	6	12
Conditions	18	0	1	1	9
Other	47	6	8	1	14
Total	**147**	**12**	**18**	**12**	**46**

* Includes doctors with unknown ethnicity and the small number of cases involving BME EEA graduates and white IMGs.

UK and EEA graduates had a higher proportion of honesty, fraud and fairness cases than IMGs. EEA graduates had a higher proportion of cases about poor diagnosis and examination than UK graduates and IMGs, and a lower proportion of cases about criminality.

BME doctors had a higher proportion of cases about criminality, whereas more cases involving white doctors were about poor diagnosis and examination.

The proportion of doctors suspended or erased from the medical register was lower for white doctors than for BME doctors. But, looking at only doctors who are erased, a similar proportion of white and BME doctors received this sanction.

Did showing insight affect the outcome of the cases?

In the cases we reviewed, showing insight was correlated with whether a doctor was erased or given a less serious sanction: doctors who showed insight were almost ten times less likely to be erased than those who did not (table 15).

Apologising and remediating after an incident can both be part of demonstrating insight. We found 60 cases in which apologising or remediating was part of showing insight – 5.0% of these cases resulted in erasure. Some doctors were also judged to have demonstrated insight without apologising or taking remedial action – this happened in 12 cases and 8.3% of these cases resulted in erasure.

A US study of legal cases against doctors showed that apologising can reduce the amount of damages awarded, and it is something that doctors want to do and to which patients respond.[35] In a study of workplace arbitration, researchers found that offering an apology can result in less severe outcomes for those referred to a panel hearing. The earlier in the process an apology is offered, the more likely it is to have a positive impact.[36]

In relatively few cases – 22 – the panel did not feel that an apology or remediation demonstrated the necessary level of insight. More of these doctors were erased (36%), although fewer proportionally than those who had not shown insight and had not apolgised or taken remedial action either (59%).

Taking remedial action seems to have an effect only in contributing to the doctor showing insight. If the doctor did not show insight, we found less difference in the outcomes of the cases between those who did or did not take remedial action.

To understand the role of insight in the panel's decision, we asked MPTS staff members who were most familiar with the 147 cases to examine whether insight, remediation or apology explicitly affected the outcome of the case.

TABLE 15: Outcomes of cases by whether the doctors showed insight, and whether they apologised or remediated the concerns

INSIGHT	Apology or remediation	Number of cases	Number of cases with each outcome				% of cases	
			Erased	Suspended	Condition	Other sanction	Erased	Suspended
Shown	Either	60	3	28	14	15	5.0%	47%
	Neither	12	1	4	2	5	8.3%	33%
Not shown	Either	22	8	10	0	4	36%	45%
	Neither	37	22	6	1	8	59%	16%
Other or not known		16	0	0	1	15	0%	0%

The numbers are small: in 69 cases, insight was considered to have affected the outcome; in 32 cases, apologising appeared to have affected the outcome; and, in 42 cases, taking remedial action was thought to have affected the outcome.

Did the type of case affect whether the doctors showed insight?

Only a quarter of doctors involved in cases about criminality showed insight (with or without apologising), compared with half of doctors across all types of case (table 16). Very few doctors involved in cases about criminality apologised, whereas we saw a high proportion of doctors apologising in cases about honesty, fraud and fairness.

Which cohorts of doctors showed insight?

As sample sizes become very small when looking at different cohorts of doctors, we confined our analysis to four groups: white UK graduates, BME UK graduates, white EEA graduates and BME IMGs. This covers 88 of the 147 cases. Of these, we had sufficient information about the role of insight, apology and remediation to analyse 75 cases.

Table 17 shows that UK graduates who apologised or took remedial action were most likely to have demonstrated insight to the panel (16 out of 18), followed by BME IMGs (16 out of 21). By contrast, two out of seven white EEA graduates who apologised or took remedial action were considered by the panel to have demonstrated genuine insight.

Graduates from different parts of the world demonstrate insight, apologise and take remedial action to different degrees, with non-UK graduates generally demonstrating less insight than others. Insight affected the outcome more often when shown by white doctors than by BME doctors, but further analysis is needed to determine whether this was due to the individual cases involved, the way insight was demonstrated or the way panel members took account of the insight in their deliberations. While there is clearly a link between place of primary medical qualification and ethnicity, with the majority of EEA graduates being white, and IMGs being BME, with only 147 panel cases to examine it is not possible to control for the effect of ethnicity and place of primary medical qualification together.

Some of this variation is likely to be caused by the seriousness and nature of the incident, but sample size is too small to determine the extent of this.

TABLE 16: Different case types in which the doctors did or did not show insight, remediate the concerns or apologise

TYPE OF CASE	Number of cases*	Insight		Remediation		Apology	
		Shown	Not shown	Shown	Not shown	Shown	Not shown
Poor diagnosis and examination	39	20	16	18	19	14	21
Honesty, fraud and fairness	46	25	17	11	31	22	20
Criminality	30	8	16	10	14	6	18
Other high risk	15	8	7	6	9	3	12
Other low risk	4	2	1	1	2	0	3
Other medium risk	11	8	3	5	6	7	4
Unknown or not categorised	2	2	0	2	0	2	0
Total	**147**	**73**	**60**	**53**	**81**	**54**	**78**

* In some instances, the MPTS staff reviewing the cases were not able to determine whether insight, remediation or apology was shown. The total number of cases includes these cases.

TABLE 17: Doctors who did or did not show insight, apologise or remediate the concerns by their place of primary medical qualification and ethnicity

INSIGHT	Apology or remediation	Number of cases†	UK graduates		EEA graduates	IMGs
			BME	White	White	BME
Shown	Either	60	6	10	2	16
	Neither	12	1	0	1	4
Not shown	Either	22	1	1	5	5
	Neither	37	2	3	4	14
Other or not known		16	2	4	0	7
Total		**147**	**12**	**18**	**12**	**46**

† Includes doctors with unknown ethnicity and the small number of cases involving BME EEA graduates and white IMGs.

Did all doctors have the opportunity to demonstrate insight to the panel?

Of the 147 cases, 111 doctors came to their panel hearing, of whom 95 had legal representation. Of the remaining 36 doctors, 34 did not come to the hearing (of whom 32 were not represented) and two could not be categorised. They may have not attended because they did not want to dispute the allegation, but it meant they did not have the opportunity to demonstrate insight to the panel. Doctors who came to the hearing had a greater chance of showing insight if they had legal representation than if they chose to represent themselves.

It may not be surprising that IMGs and EEA graduates were less likely to have legal representation than UK graduates, but this small study found it was EEA graduates who were most likely to be unrepresented – 46% were represented, compared with 63% of IMGs and 79% of UK graduates.

Interestingly, a lower proportion of white doctors (51%) had legal representation than BME doctors (71%). BME UK graduates were represented in all 12 cases, and white UK graduates were represented in ten out of 18 cases (56%).

In our information for doctors whose cases are due to be heard by a fitness to practise panel, we suggest that doctors should consider carefully being advised and represented by solicitors who have experience of MPTS hearings, as they will know how to prepare a case and present the information that the panel needs.

BOX 5: Key findings

Doctors at higher risk of being complained about, being investigated or receiving a sanction or a warning are:

- male doctors compared to female doctors overall
- male doctors over 50 years old who are EEA graduates or IMGs
- male GPs aged 30–50 years who are EEA graduates or IMGs
- among UK graduates, BME doctors more than white doctors
- specialists in psychiatry, surgery and obstetrics and gynaecology, with particular risks associated with cosmetic surgery
- doctors attached to locum agencies.

Why are these doctors at higher risk?

- To some extent, doctors with different demographic characteristics – particularly BME doctors and non-UK graduates – have different types of allegation against them.
- When the case gets as far as a panel hearing, non-UK graduates are less likely to have shown sufficient insight into what they have done wrong, making it more likely that the panel will choose a more serious sanction to protect patients in the future.

Implications of our key findings

The reasons for some doctors being at higher risk, outlined in box 5, are important for the medical profession to consider and for us to investigate further. The findings suggest that it may not be some groups are generally at higher risk of complaints or more serious sanctions, but instead that there are specific types of allegation that these groups are more likely to have raised about them. This opens up the possibility for targeted preventative support for particular groups – for example, through our new 'welcome to UK practice' service – on specific areas that doctors new to UK practice seem to struggle with.

We need to do a fuller study of cases to confirm this finding – there are many confounding factors, such as seriousness and nature of individual cases, that might explain some of the differences we have seen.

Chapter 3: Preparing doctors through medical education and training

Medical education in the UK begins with recruitment to medical school, and continues throughout the doctor's career. One of the first major tests of the education process is when a student emerges from medical school and takes up their first post as a provisionally registered doctor in foundation training. In this chapter we consider how well medical schools are preparing their students for this first step and more generally for a career in medicine.

The GMC sets the standards for undergraduate and postgraduate medical education and training (box 6, page 112), and carries out regular monitoring to check whether medical schools and training organisations (largely hospitals and GP surgeries) are meeting these standards.

The GMC quality assures undergraduate education through its quality improvement framework – for example, through visits, observing exams, annual reports from each school and desk-based audits.

As with other areas of the GMC's work, we are increasingly using medical education data to understand and inform our work and to help others involved in this field. Data analysis can help identify areas of excellence, show where standards are not being met, improve quality by identifying where more support is needed, and increase knowledge about risks to patients, particularly when studied alongside data from other organisations.

In this chapter we describe how prepared foundation doctors feel for entering practice and some factors that affect their preparedness. We go on to discuss what happens when a doctor struggles to progress through their training, explore some factors that affect preparedness, and highlight what is being done to improve it. We also look at how well medical schools are preparing their graduates for practice and which specialties their graduates choose.

Definitions

Medical student: an undergraduate student or a graduate entry student at one of the UK's 33 medical schools.

Foundation doctor: a doctor in foundation training.

- **F1 doctor:** a doctor in the first year of foundation training after graduating from medical school. This doctor is provisionally registered with the GMC.
- **F2 doctor:** a doctor in the second year of foundation training. This doctor is fully registered with the GMC.

Core training: some postgraduate training programmes have this initial period of common training. For example, a doctor may go through core medical training before moving on to more specialist training in geriatric medicine.

Doctor in specialty training: a doctor in an approved postgraduate training programme. Once they complete the programme, the doctor will receive the Certificate of Completion of Training (CCT). The doctor can then apply to join the GP or Specialist Register. Specialty training may include a component of core training before further higher specialty training.

Doctor in training: a doctor who is in foundation or specialty training (including GP training).

BOX 6: GMC standards for medical education

The GMC sets the standards for both undergraduate and postgraduate education. The standards are set out in *Tomorrow's Doctors*[37] for undergraduate education and in *The Trainee Doctor*[38] for postgraduate medical education (this includes foundation, core and specialty training).

Tomorrow's Doctors includes:

- **the outcomes for graduates:** the knowledge, skills and behaviours that medical students are expected to learn
- **the standards for delivery:** how medical schools must support and assess students.

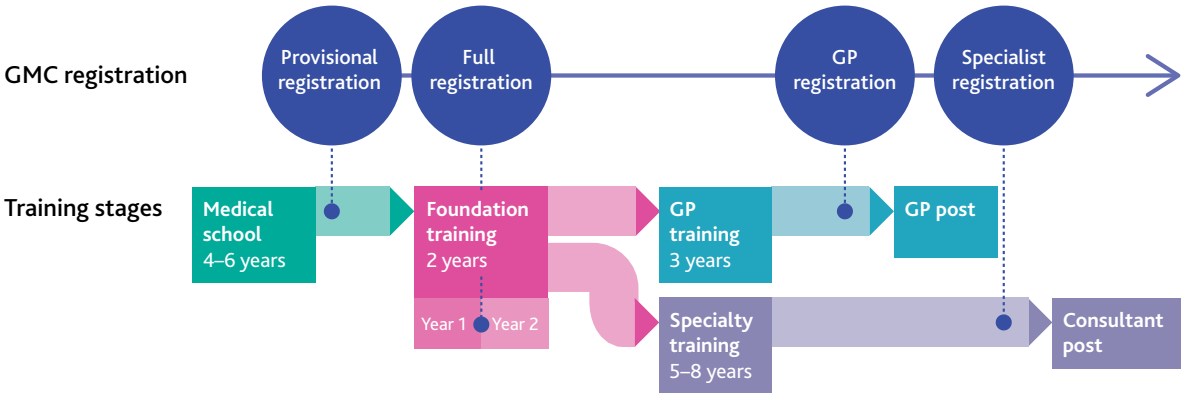
The 2009 edition of *Tomorrow's Doctors* sets out the competences required of graduates in more detail, and places greater emphasis on prescribing and professionalism than previous editions. It also includes more specific requirements about how to assess students, which has led to reforms such as the introduction of student assistantships.

We have just completed a review of the impact of this edition of *Tomorrow's Doctors* to see how well medical graduates are prepared for working as doctors. The findings of the review will be used to revise the outcomes required of graduates.[39]

At the start of 2014, there were 40,625 medical students, 7,759 F1 doctors, 7,636 F2 doctors, 10,746 doctors training to be GPs and 32,328 doctors training to be specialists.

The stages from medical school through to completion of specialty training are set out in figure 54.

FIGURE 54: **The stages of medical education**



The national training survey and other sources of data

The GMC operates the largest survey of doctors in training anywhere in the world. The survey is now widely used by those involved in medical education, as well as by healthcare providers, patient safety organisations and other regulators. Completion of the survey is compulsory for doctors in training and the response rate for the 2014 survey was 98%, capturing the views of over 50,000 doctors training in the UK.

Local education providers (LEPs), such as hospitals and GP surgeries, use the findings to improve how they train doctors. The findings also help postgraduate deaneries and local education and training boards (LETBs) manage training programmes, which are usually delivered across several LEPs.

The survey consists of a set of generic questions that test whether doctors think those who provide their training are complying with GMC standards. It also includes programme-specific questions, which are developed in conjunction with medical royal colleges, faculties and the UK Foundation Programme Office (UKFPO), and are designed to test doctors' views of their individual training programmes.

We also gather data from other sources:

- outcomes of the annual review of competence progression (ARCP), which every doctor in specialty and GP training has to undergo
- data and intelligence from the UKFPO, which oversees the Foundation Programme
- feedback of various kinds from those who act as clinical trainers and from employers of doctors in training.

In addition, we receive annual reports from each of the medical royal colleges and from the local bodies that oversee postgraduate training. Our own inspections and checks also produce information and data about the state of medical education.

For our review of *Tomorrow's Doctors,* we also commissioned a rapid review from Cardiff University of recent academic literature on the transition from medical school to practice.[40] The researchers interviewed 185 doctors, including 34 F1 doctors and 33 F2 doctors; 26 F1 doctors kept audio diaries. As part of this exercise, we also reviewed other evidence.[39] The aim was to establish how prepared F1 doctors think they are for their first post, any weaknesses in their work as they take on their new role, how well medical schools are preparing new doctors, and why some struggle to progress.

How prepared do F1 doctors feel?

We know how well prepared F1 doctors – both UK and non-UK graduates – think they are for their first post from their answers to our national training survey in 2014.[41] However, we don't know to what extent their perceptions are affected by the working environment and culture, the level of advice and support from senior doctors, and whether their post is located in the deanery or LETB where they were at medical school, in a hospital they are familiar with, or elsewhere.

In the national training survey, we ask doctors in training to tell us how much they agree or disagree with the statements in table 19% agreed that they were adequately prepared for their first foundation post.* 74% agreed the skills they learnt at medical school set them up well for working as a foundation doctor.

TABLE 18: How much F1 doctors agreed or disagreed with two statements in the national training survey (2014)

SURVEY STATEMENT		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
'I was adequately prepared for my first foundation post'	Number of doctors	889	4,387	1,612	618	96	14
	% of doctors	12%	58%	21%	8.1%	1.3%	0.2%
'The skills I learned at medical school set me up well for working as a foundation doctor'	Number of doctors	1,337	4,343	1,319	565	86	6
	% of doctors	18%	57%	17%	7.4%	1.1%	0.1%

* Unless otherwise indicated, all data in this section are from our national training survey, in 2014 or in previous years, and all data are for F1 doctors. 'Agree' is equal to a response of strongly agree or agree, and 'disagree' is equal to a response of disagree or strongly disagree, except where specifically stated.

Some new doctors struggle with increased responsibilities

Tomorrow's Doctors recognises that graduates need to acquire several attributes to practise as a doctor, including good time management, the ability to cope with uncertainty, and good basic clinical skills. The audio diaries of a small sample of F1 doctors in the Cardiff University study[40] found that these new graduates did experience some difficulties adapting to their new responsibilities – such as time management in a busy care environment.

There are clearly risks to patient safety during the time that doctors in training move into new roles, and particularly when new graduates are introduced to hospital settings. While these issues are being addressed through the development of student assistantships and new arrangements for the induction of F1 doctors, the Cardiff study does suggest there is scope for further improvement. This should be seen in the context of the results from the national training survey, which showed that, six months into their placements in 2014, 69% of F1 doctors agreed that they were adequately prepared, 9.4% disagreed, and 21% neither agreed nor disagreed.

It is against our standards for F1 doctors to be working unsupervised by a senior clinician. We undertook a review in 2012–13 of training in emergency departments, including those training F1 doctors. The review showed departments that had combined services onto one site had a more robust rota, which meant that supervision for doctors in training was stronger. We also found that a more intensive induction, an increase in 'shop-floor' teaching and use of simulation helped to extend the breadth of knowledge, giving the doctors in training a better educational experience and more confidence when dealing with patients.

Some of the sites paired clinical supervisors with doctors in training who had a similar interest, meaning that the supervisor could engage in detail with one curriculum and focus more effectively on delivering the training required. The doctors in training fed back positively on this. The Academy of Medical Royal Colleges has recommended changes to scheduling work so that foundation doctors get experience during the day, with full staffing, before they go on call on that ward when there may be fewer staff working on site.[42]

Perception of the quality of clinical supervision appears to have slightly increased

Making sure doctors get practical experience under safe supervision is fundamental to good training. In the national training survey, we ask F1 doctors five questions to measure the quality of clinical supervision.* A high score out of 100 indicates good clinical supervision, whereas a low score indicates that patients and doctors in training could be put at risk. The clinical supervision score has slightly increased over the past three years from 85.18 in 2012 to 85.42 in 2013 and 87.36 in 2014.

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

Today's F1 doctors believe they are better prepared than previously

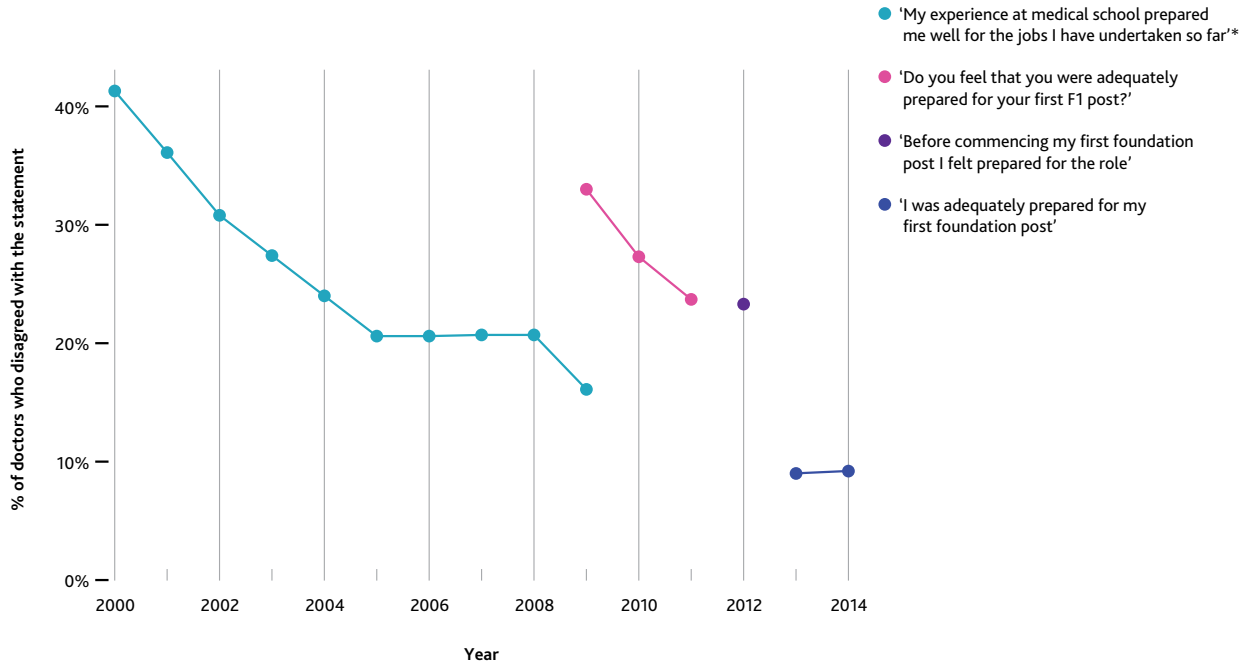
In 1999, just over a third of doctors interviewed a year after graduation agreed they had been well prepared for their first foundation post. By 2002, this had risen to a half of doctors and, by 2005, to almost three-fifths, before falling back to a half in 2009.[43]

After we published the latest edition of *Tomorrow's Doctors* in 2009 – which was substantially different from its predecessor, setting out clear competences required of medical school graduates and introducing student assistantships – the rise in preparedness appears to continue. The percentage of those disagreeing with the statement 'do you feel that you were adequately prepared for your first foundation post?' declines from 34% in 2009 to 24% in 2011. Due to question changes, it is difficult to ascertain whether percptions of preparedness have improved further since then.

The proportion of F1 doctors who said they had felt forced to cope with clinical problems beyond their competence or experience monthly, weekly, or daily in their current post decreased from 51% in 2009 to 31% in 2014. Although that proportion may still sound high, inevitably F1 doctors will have to deal with the unexpected. With good follow-up and debrief, these can be valuable learning experiences. The reduction by 20% may indicate, though, that there has been a move to more conservative supervision and training, as well as an actual improvement in preparedness.

The proportion who said they never faced such situations rose from 8% in 2009 to 23% in 2014. Whether this is due to greater preparedness or to change in the way responsibility is given to F1 doctors, it probably does reflect a reduction in the risk posed to patients and it may indicate improved training for these doctors.

FIGURE 55: **Trends of F1 doctors disagreeing that they were prepared for their first foundation post**



* These data are for F1 doctors from Goldacre and colleagues' study,[43] whereas all other data are from the national training survey.

How well are medical schools preparing doctors?

Each of the 33 medical schools in the UK sets the entry grades that students need to get a place at their school, and decides what to include in its undergraduate curriculum and how to teach it, subject to our curricular requirements. Unsurprisingly then, our recent review[44] found considerable variation in the way medical schools assess students' progress.

On the whole, the review showed medical schools were delivering assessment in line with our standards in *Tomorrow's Doctors*, and we found many examples of good practice that could benefit others. Most medical schools had effective assessment strategies, setting out their approach to assessment and how it fits within the wider curriculum, and showed evidence of reflection and continual review. However, variability does exist and the GMC needs to take steps to better promote best practice, and to develop a better understanding of the causes and consequences of this variation.

Self-perceptions of preparedness vary across medical schools

Across medical schools that had a cohort of doctors completing their full undergraduate medical degree in 2013, 9% of graduates believed they were not adequately prepared for their first foundation post in 2014.* For ten medical schools, at least 10% of graduates believed they were not adequately prepared once they started work. Five schools had fewer than 5% of doctors who felt unprepared.

Overall, the proportion of graduates who felt adequately prepared varied from 60% to 85% (table 19).

- For five medical schools, at least 80% of graduates felt prepared.
- For seven medical schools, 70–79% of graduates felt prepared.
- For 17 medical schools, 60–70% of graduates felt prepared.

The proportion of graduates who felt they had not obtained the skills needed to set them up for practice varied from 1% to 16% across medical schools. Between 62% and 97% felt they had gained these skills.

* F1 doctors were asked to give one of five answers to the statement 'I was adequately prepared for my first foundation post' – strongly agree, agree, neither agree nor disagree, disagree or strongly disagree.

TABLE 19: **Preparedness of F1 doctors by medical school (2014)***

MEDICAL SCHOOL	Number of respondents	% of respondents who agreed with the following statements	
		'I was adequately prepared for my first foundation post'	'The skills I learned at medical school set me up well for working as a foundation doctor'
University of Aberdeen	165	73%	86%
University of Birmingham	408	66%	68%
University of Brighton and University of Sussex	151	69%	81%
University of Bristol	233	64%	73%
University of Cambridge	144	60%	62%
Cardiff University	383	61%	65%
University of Dundee	149	81%	93%
University of East Anglia	147	85%	97%
University of Edinburgh	242	74%	75%
Universities of Exeter and Plymouth	199	84%	93% †
University of Glasgow	263	74%	68%
University of Hull and University of York	143	70%	78%
Imperial College London	366	64%	62%
Keele University	127	83%	95%
Kings College London	364	68%	70%
University of Leeds	264	75%	86%
University of Leicester	236	67%	74%†
University of Liverpool	310	69%	80%
University College London	362	70%	80%
University of Manchester	416	75%	79%
University of Newcastle upon Tyne	345	68%	74%
University of Nottingham	308	69%	64%
University of Oxford	158	82%	84%
Queen Mary, University of London	607	67%	72%†
Queens University of Belfast	240	68%	71%
University of Sheffield	227	68%	63%
University of Southampton	238	63%	67%
St George's, University of London	43	74%	88%
The University of Warwick	165	71%	74%†
Total	7403	70%	74%

* Excludes data for two universities. The GMC gave Lancaster University permission to award a UK primary medical qualification in November 2012, with its first cohort independent of the University of Liverpool beginning their studies in 2013. The GMC gave University of Swansea permission to award a UK primary medical qualification in 2014, with its first cohort graduating independently of Cardiff University in 2014.

† There was one fewer respondent for this question.

Doctors who feel less prepared have poorer ARCP outcomes

All doctors in training have a review at least once a year to make sure they are progressing as they should – this is known as the annual review of competence progression (ARCP, box 7). 2013 is the first year that we have these data for F1 doctors as the ARCP was introduced into foundation training in 2012.

F1 doctors who reported they were not adequately prepared for their first post were more likely to receive unsatisfactory ARCP outcomes (figure 56).

- Of those who did not get an unsatisfactory outcome, 70% agreed or strongly agreed that they were adequately prepared for their first foundation post, and only 8.3% disagreed or strongly disagreed.
- Of those who got an unsatisfactory outcome, 49% agreed or strongly agreed that they were adequately prepared, and 25% disagreed or strongly disagreed.

This difference may be larger than the underlying reality. F1 doctors start to gather evidence for their ARCP from the beginning of training, usually in August, but we asked the question in the national training survey in March–May, between seven and nine months later. Their response to the national training survey will be affected by several months of informal feedback from their trainers, and, where this is positive or negative, we might expect their understanding of their own preparedness to be shaped accordingly.

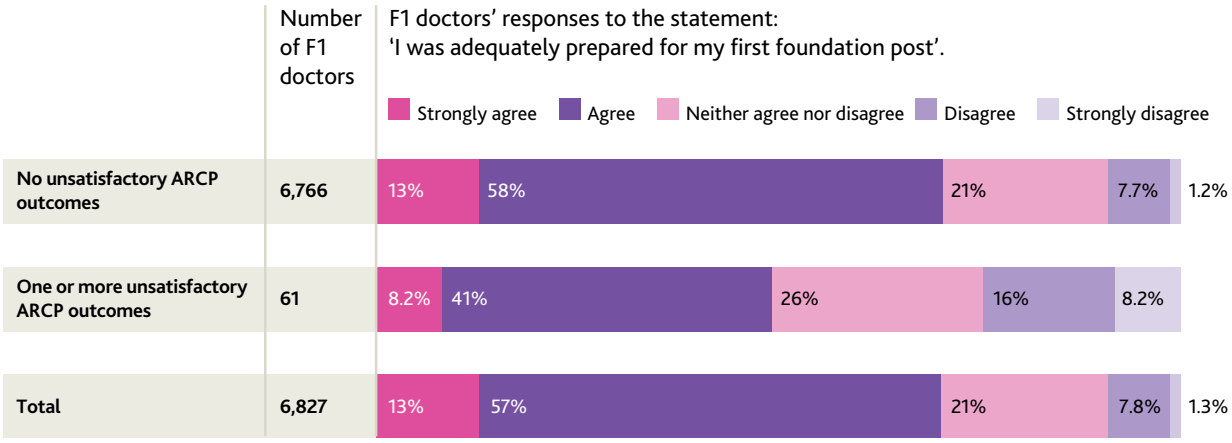
In future, further analysis should be able to verify the validity of the relationship between preparedness and an unsatisfactory ARCP outcome.

Box 7: How does the ARCP work?

A panel of clinical examiners reviews a doctor's portfolio of evidence about their progression. The review places more emphasis on evidence than on face-to-face meetings between the panel and the doctor in training. Each specialty has its own process that follows the *Gold Guide*,[45] and the process for foundation doctors follows the *Guide to Foundation Annual Review of Competence Progression (ARCP)*.[46]

The doctor in training does not receive a grade – instead there are a range of outcomes. For example, the doctor may progress to the next stage of training, having demonstrated all of the competences required for that stage. This is regarded as a satisfactory outcome. Alternatively the doctor may progress to the next stage with some competences outstanding or they may be given extra time at their current stage to demonstrate outstanding competences, both of which are regarded as unsatisfactory outcomes. Finally the doctor could be released from the programme, which is also an unsatisfactory outcome. Some doctors may have several unsatisfactory outcomes during the course of postgraduate training.

FIGURE 56: Relationship between self-reported preparedness in the 2013 national training survey and receiving an unsatisfactory ARCP outcome for the training year from 1 August 2012 to 6 August 2013[*,†]



* Agreement with the statement 'I was adequately prepared for my first foundation post' was correlated with receiving no unsatisfactory ARCP outcomes in F1 training ($p<0.001$ using a Mann-Whitney U test).

† The term 'unsatisfactory ARCP outcomes' refers to outcome 2, 3, 4, 7.2, or 7.3, or, where applicable, to in-training assessment (RITA) outcome D or E. We have not included ARCP outcome 5 'insufficient evidence required'. Further detail on these categories is available at www.gmc-uk.org/education/23861.asp. The data collection notices, other background information, and reporting by deanery or LETB can be found at www.gmc-uk.org/education/arcp.

Employers and trainers are concerned that F1 doctors are not adequately prepared

The average percentage of doctors who feel prepared has increased since 2009, but some trainers and employers* remain concerned about the preparedness of F1 doctors.[39]

In a 2009 survey of employers, some respondents thought that standards were generally improving, with some excellent foundation doctors, but many respondents felt that foundation doctors were generally not meeting the needs and expectations of the current NHS.[47] They were concerned about 'confidence and competence in clinical decision making, clinical procedures and prescribing in practical situations, lack of understanding of the NHS and how it works, and standards of professionalism which are below those generally expected of NHS employees'.[47] This survey was conducted to feed into the review that led to the 2009 edition of *Tomorrow's Doctors*. As a result, the requirements of new graduates were revised and medical schools have developed student assistantships to give all medical students hands-on experience in clinical environments before they graduate.

Nevertheless, in our work to support the independent review of the shape of postgraduate training in 2012–13, we met employers who still had concerns that many new graduates were not fit to take up their foundation posts.[48] Some observed that F1 doctors often lacked professionalism and essential skills – and some employers claimed that they had to teach F1 doctors basic skills as part of their postgraduate training.

In addition, there is continuing evidence that those who train doctors (usually hospital consultants and senior GPs) remain concerned about aspects of the preparedness of new graduates.[40, 49] Indeed, a number of surveys have indicated that trainers think graduates are less prepared than the graduates recognise themselves. However, the number of foundation doctors identified as being in difficulty and in need of additional support is relatively small. Out of a total cohort of more than 7,700, foundation schools reported that 193 F1 doctors and 185 F2 doctors needed additional support.[50]

The perceptions of employers and trainers are crucially important and it would be helpful to have more systematic evidence of how they regard new doctors and what they feel needs to be done to continue making improvements to their training. It may be that, from their perspective, a lack of preparedness goes wider than the very small numbers of new graduates who are formally recognised as doctors in difficulty† or who fail to progress in their training in the standard timescale. This indicates the importance of involving and listening to employers and trainers, and moving towards greater alignment in the expectations of new doctors.

* Medical directors and other clinical managers in trusts, health boards and other healthcare providers.

† A doctor in difficulty is a doctor in training who the foundation school, or the LETB or deanery, has identified is having difficulty carrying out their work or progressing as expected and would be likely to benefit from additional support and closer supervision.

Mechanisms to improve preparedness

Students at medical schools must be properly prepared to be able to practise effectively as doctors after graduation. We want to reduce any risks associated with this transition as much as possible.

In the past few years, since the first edition of *Tomorrow's Doctors* in 1993, several mechanisms have been introduced to improve preparedness to practise. These include student assistantships and prescribing safety assessments.

Student assistantships

In the last year of medical school, students have a clinical placement called a student assistantship, where they assist an F1 doctor with defined duties under appropriate supervision. This is intended to be a hands-on learning experience that allows the medical student to gain experience of working within clinical settings and to practise clinical skills.[51] Student assistantships were introduced following the revision of *Tomorrow's Doctors* in 2009 and are increasingly valued.[52]

Many doctors in training believe the best way to improve undergraduate medical education would be to increase the amount or quality of practical experience.[53] Medical students who have a more hands-on assistantship seem to have a smoother transition to working as a doctor.[40] When asked about how to improve training at medical school, the main suggestion from doctors in training is to increase hands-on experience.[41] In a 2012 study, both doctors in training and their educational supervisors said that the most useful learning opportunities from assistantships were on prescribing, managing acutely unwell patients and prioritising ward tasks.[40]

Prescribing safety assessment

The prescribing safety assessment was run by all UK medical schools in 2014 after a national pilot in 2013. This is a pass or fail assessment of final-year medical students' skills, judgement and supporting knowledge related to prescribing medicines. It was developed by the Medical Schools Council and the British Pharmacological Society, based on the competences outlined in *Tomorrow's Doctors*.

The competences that medical students should achieve include being able to write new and review existing prescriptions, calculate drug doses, identify and avoid adverse drug reactions and medication errors, and tailor prescribing to suit an individual patient's circumstances. The content is relevant to the prescribing tasks expected of an F1 doctor.[54]

Doctors who get into difficulty in their first years of practice

While much effort is put into the medical education of doctors in training by clinical trainers and others, there will always be those who find professional practice more difficult than others.

As we have seen, employers and trainers are concerned that F1 doctors are not always adequately prepared. But, in practice, only a very small proportion of foundation doctors find themselves officially falling below the standards expected of them.[39] This is usually caused by health or personal problems, poor attitudes and behaviours, lack of knowledge or skills, or a combination of these.[55]

When a doctor in training is not progressing as expected – as identified by their clinical trainers and supervisors – the UK Foundation Programme Office (UKFPO) *Reference Guide* describes how to identify and support them.[55] Educational and clinical supervisors are required to keep a close eye on the doctor's work and to provide the necessary support. Of course a doctor in training could find themselves in difficulty at any stage from foundation, through to core and higher specialty training, but here we concentrate on doctors in foundation training.

For a deanery or LETB to have a number of doctors identified as being in difficulty is not necessarily a sign that something is wrong with the training in that area. This may indicate that doctors in difficulty are being identified and supported earlier. Doctors in training who do not get signed off by their agreed end time are a potential source of information on where these doctors might be struggling to cope with personal or professional difficulties during their medical education or training, or it may show where doctors are not being provided sufficient support in their learning.

The proportion of doctors in difficulty is declining

Postgraduate deans reported to the UKFPO that there were 378 foundation doctors in difficulty in 2013 – 2.6% of F1 doctors and 2.4% of F2 doctors.

- 135 were subsequently signed off as fit to continue training by the agreed end date.
- 187 were forced to repeat all or part of the first or second year of foundation training.
- 36 left medicine.
- 20 did not have their outcome reported by the UK Foundation Programme Office.

Overall, the proportion of doctors in difficulty has been declining: in 2010, 4.6% of F1 doctors and 4.2% of F2 doctors were in difficulty. This may suggest that the weakest doctors are becoming better prepared, although we cannot say this with confidence as the numbers may have been affected by local changes. In this climate of financial constraint there are inevitable pressures on programmes to support doctors in training.[39]

The proportion of doctors in difficulty who had graduated from UK medical schools varied from 0% for some schools up to 2.7% for others, with the number for all UK graduates being 2.2% (table 20). By contrast, the very small number of doctors graduating from medical schools in the European Economic Area (EEA)* were more than twice as likely as any UK graduates to be in difficulty, and th small number of international medical graduates (IMGs)† were between three and four times more likely.

TABLE 20: Doctors in difficulty by place of primary medical qualification (2013)

PLACE OF PRIMARY MEDICAL QUALIFICATION	Number of foundation doctors	% of doctors in difficulty
UK graduates	14,628	2.2%
EEA graduates	335	5.4%
IMGs	432	7.9%

What are foundation doctors unprepared for?

In Monrouxe and colleagues' study,[40] some F1 doctors felt unprepared for the step change in responsibility, the workload, the degree of multitasking, deciding who and when to ask for help, understanding how the hospital works (which varied by hospital) and dealing with the underperformance of other team members.

Prescribing

In England, adverse events involving medication were the fourth most common type of incident reported during 2008 to the National Patient Safety Agency (80,150 incidents).[56] Research from the Health & Social Care Information Centre shows the number of prescriptions written per year rose by 385 million between 2002 and 2012, with over a billion prescriptions written in 2012.[57]

GMC staff had 68 requests in 2013 from medical students in England wanting to discuss prescribing with our regional liaison service – this was more than for any other area of practice (figure 57, page 135). This appears to show that some students are taking this topic seriously and want to know more about prescribing.

* 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.

The GMC commissioned a study of prescribing errors in general practice (PRACTiCe), which was published in 2012.[58] This found that one in 20 prescription items contained either a prescribing or a monitoring error, affecting one in eight patients. Although the majority of errors were judged to be of either mild or moderate severity, one in 550 of all prescription items contained an error judged to be severe.

The PRACTiCe study, and a study in secondary care in 2009 (EQUIP),[59] point to the importance of training and preparedness for prescribing. The EQUIP study found errors in 8.4% of prescriptions by F1 doctors in secondary care, but, of these, fewer than 2% of prescribing errors were potentially lethal. The report stressed that very few prescribing errors caused harm to patients because almost all were intercepted and corrected before reaching them. The intervention of nurses, senior doctors and, in particular, pharmacists was vital in picking up errors before impacting on patients.

Contributing factors to these errors included a lack of training, interruptions and distractions, and a failure to fully use existing IT solutions for safer prescribing.

To make sure doctors understand the standards expected of them, last year we introduced the guidance *Good practice in prescribing and managing medicines and devices*.[29] And, as mentioned previously, the Medical Schools Council and the British Pharmacological Society have developed the prescribing safety assessment for all final-year medical students.

Clinical procedures

Trainers have reported concerns about F1 doctors carrying out clinical procedures such as venepuncture, cannulation and arterial blood gas (ABG) tests.[60] Applicants to the Foundation Programme, when surveyed on the 32 practical procedures listed in *Tomorrow's Doctors* by the UKFPO, most often rated themselves not competent in nutritional assessment, insulin administration and blood transfusion. However, just to keep this in perspective, it is worth noting that in a systematic review of clinical skills in a number of countries across the world, foundation doctors working in England had the lowest deficit of clinical skills experience.[61]

Reporting risks to patient safety

Across the UK there has been a strong focus on incident reporting following the Mid Staffordshire inquiry.[1] The Department of Health in England has taken a number of steps,[62] including the introduction of a duty of candour, subject to parliamentary approval, on all health and social care organisations in England.[2] The GMC and other health regulators have developed a professional duty of candour, reflecting current requirements on doctors to be open and honest, to report adverse incidents and inform patients whenever harm may have been caused.

NHS England has introduced Patient Safety Collaborative Programmes in a network across the country, bringing together frontline teams, experts, patients, commissioners and others to tackle specific patient safety problems, as well as learning from each other to improve safety.

The Berwick review into patient safety in England recommended that medical education should focus more on how to ensure high-quality care and what to do if patient safety is at risk. The review said this should be an initial and lifelong part of educating all healthcare professionals.[63]

In its response to the Mid Staffordshire inquiry – *Delivering Safe Care, Compassionate Care* – the Welsh Government laid out its commitment to openness, compassion and delivering patient-centred care.[64] It also emphasised its expectations of the NHS in Wales to commit to greater transparency, improved communication with staff and patients, and better standards of healthcare.

The Scottish Government said it would examine how the recommendations in the Mid Staffordshire inquiry could be applied in Scotland, such as introducing a duty of candour for health boards.[65] Scotland already has a patient safety programme, introduced in 2008, which was one of the inquiry's recommendations for England.

Monrouxe and colleagues' literature review[40] found three studies,[66, 67, 68] one of which was large scale,[66] where the data suggest that doctors in training are unprepared for reporting and dealing with error and safety incidents.

The large-scale study[66] of healthcare professionals training in nursing, physiotherapy and occupational therapy, as well as doctors, used focus group discussions, observed learning activity, and studied key documents and curricula of doctors. It found the different professional groups defined patient safety differently, and doctors tended to focus on diagnostic errors and high-risk procedures rather than wider issues. It also found that explicit teaching about systems for incident reporting was not common – patient safety was often viewed as an implicit part of the curricula and as an overall outcome of the teaching programme, rather than taught as a distinct area of competency.

Communicating effectively with patients

Many of the 67 F1 and F2 doctors interviewed in Monrouxe and colleagues' study appeared unprepared for many communication challenges, including:

- dealing with angry or upset patients and relatives
- managing complaints
- communicating with patients whose first language was not English
- communicating with vulnerable patients, including those with mental health issues
- breaking bad news
- dealing with more informed patients.

The doctors frequently reported distress during and after the incidents.

As noted above, the Mid Staffordshire inquiry[1] called for more openness and transparency when dealing with patients, and the Department of Health in England is introducing a duty of candour for health and social care providers.[69] It is clear though that such initiatives may be hindered if new doctors feel unprepared to communicate with patients and their relatives on difficult topics.

Medical schools may be preparing their graduates for different areas of practice

There are wide variations across medical schools in what specialty their graduates train in after they complete their foundation training (table 21). Oxford and Cambridge medical schools have a higher proportion of graduates becoming physicians or surgeons. Other schools produce a higher percentage of GPs.

Table 21 relates to doctors who joined the GP or Specialist Register. Not all doctors join the GP or Specialist Register – 9,020 doctors graduating from a UK medical school had not joined within 13 years of graduating.

TABLE 21: Percentage of UK graduates who became provisionally registered in 1990–2001 and joined the GP or Specialist Register by 16 March 2014*

MEDICAL SCHOOL	Specialty group on the Specialist Register†													
	GP Register	Medicine	Surgery	Anaesthetics	Psychiatry	Radiology	Paediatrics	Emergency medicine	Obstetrics and gynaecology	Pathology	Ophthalmology	Other	Not recorded on the GP or Specialist Register	**Number of graduates from this school**
University of Aberdeen	38%	10%	7%	6%	4%	2%	2%	2%	1%	2%	1%	1%	24%	**1,506**
University of Birmingham	41%	11%	8%	9%	5%	3%	4%	2%	1%	1%	1%	1%	15%	**1,961**
University of Bristol	31%	13%	11%	9%	3%	4%	3%	2%	1%	1%	1%	2%	19%	**1,515**
University of Cambridge	17%	23%	12%	4%	3%	5%	5%	1%	1%	2%	2%	2%	21%	**1,589**
University of Dundee	39%	9%	6%	7%	4%	3%	3%	2%	1%	1%	1%	2%	22%	**1,428**
University of Edinburgh	29%	16%	6%	8%	6%	3%	4%	2%	2%	1%	1%	2%	19%	**2,223**
University of Glasgow	32%	13%	7%	7%	5%	3%	3%	2%	2%	2%	1%	1%	22%	**2,536**
University of Leeds	39%	13%	7%	7%	4%	3%	4%	3%	1%	1%	1%	1%	16%	**1,860**
University of Leicester	43%	10%	6%	6%	3%	3%	3%	2%	2%	1%	1%	1%	20%	**1,525**
University of Liverpool	41%	11%	7%	5%	5%	2%	2%	3%	2%	1%	0%	1%	18%	**1,819**
University of London	33%	13%	9%	7%	4%	5%	3%	2%	1%	1%	1%	1%	19%	**14,387**
University of Manchester	37%	9%	8%	7%	4%	4%	3%	2%	1%	1%	1%	2%	19%	**3,181**
Newcastle University	38%	15%	7%	7%	4%	2%	3%	3%	1%	0%	1%	2%	16%	**1,704**
University of Nottingham	33%	13%	8%	8%	3%	4%	5%	1%	2%	1%	1%	1%	19%	**1,719**
University of Oxford	16%	27%	13%	5%	4%	7%	3%	1%	1%	2%	2%	1%	19%	**1,178**
Queen's University Belfast	30%	14%	7%	6%	5%	5%	3%	2%	2%	2%	1%	1%	21%	**1,748**
University of Sheffield	41%	11%	8%	6%	4%	3%	2%	2%	1%	2%	1%	1%	18%	**1,848**
University of Southampton	37%	13%	6%	7%	4%	3%	3%	2%	1%	1%	2%	1%	20%	**1,582**
University of Wales	43%	11%	9%	6%	3%	3%	3%	2%	1%	1%	1%	1%	16%	**1,829**
Total number of graduates	**16,259**	**6,168**	**3,923**	**3,227**	**1,971**	**1,774**	**1,487**	**894**	**673**	**566**	**544**	**632**	**9,020**	**47,138**

* We have data for 19 medical schools. Where a medical school split into more than one school between 1990 and 2001, or where a medical school change name, the data are kept in the name of the first medical school. For example, the University of Wales became the Universtity of Cardiff and in this table it is called the University of Wales only.

† Specialties were grouped according to medical royal college in line with the graduate specialty destination tool available on the GMC website at http://tinyurl.com/necazq3.

How do the characteristics of foundation doctors affect preparedness and attainment?

Ethnicity affects doctors' attainment from secondary school onwards

When leaving secondary school, white students are less likely to apply to medical school than black and minority ethnic (BME)* students, but they are more likely to get into a medical school, partly due to differences in entry grades.[70]

One study by McManus, Woolf and Dacre[71] looked at the educational background and qualifications of BME medical students studying in the UK. It found that BME students achieved lower GCSE and A-level grades than white students and got lower marks than white students. The same study also found that, on average, BME medical students came from poorer socioeconomic backgrounds, but, even after secondary school results and socioeconomic background were accounted for, BME students underperformed relative to white students at medical school. In Woolf and colleagues' systematic review[72] of attainment in academic assessments across medical school and postgraduate medical training, 22 of 23 studies showed robust evidence that BME medical students and doctors performed poorly relative to their white counterparts.

The attainment gap between BME and white students in higher education extends beyond medical school: across all subjects, 67% of white students achieve first or upper second class degrees, but only 49% of BME students do (38% of black students).[73] This gap can only partly be explained by school performance, but we don't know what causes it.[73] This attainment gap has not changed in the past decade, and is present across higher education.[73]

In a meta-analysis[72] of undergraduate and postgraduate assessments, researchers compared multiple choice written assessments marked by machines with practical clinical assessments marked by assessors and found similar patterns with BME doctors less likely to progress. The researchers concluded that bias from assessors could not explain the difference in attainment. Several factors may be at play here, such as the impact of students' chosen circles of friends on their academic attainment.[74] We do not know whether the different grades are caused by the undergraduate experience, or whether teaching and assessment factors affect different ethnic groups.

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

Graduates aged under 30 feel slightly better prepared than older graduates

Throughout students' and doctors' education there are many factors that relate to their academic performance, and the relationship between factors is often complex. McManus and colleagues found, for example, that female doctors performed better in assessments overall than male doctors, but were less likely to be on the Specialist Register, while BME doctors performed less well than white doctors, but were equally likely to be on the Specialist Register.[75] This is similar to findings by the Higher Education Funding Council for England, which found that female students tended to achieve first and second class degrees more frequently, while black and Asian students achieved them less, even when accounting for their A-level scores on entry to university.[76]

Place of primary medical qualification is a strong factor for whether F1 doctors felt prepared for their first foundation post. Only 46% of the 100 EEA graduates who responded said they felt prepared in the 2014 national training survey, compared with 80% of 111 IMGs and 74% of 7,399 UK graduates.

We know that male and female F1 doctors report that they felt similarly prepared – for UK graduates 74% of males and 75% of females agreed with the statement 'the skills I learned at medical school set me up well for working as a foundation doctor'.

When broken down by ethnicity, 71% of BME UK graduates who were F1 doctors said that the skills they learned at medical school set them up well for working as a foundation doctor, compared with 76% of their white counterparts.

Age also affects how prepared doctors feel. 75% of UK graduates under 30 years old who were F1 doctors said that the skills they learned at medical school set them up well for working as a foundation doctor, compared with 69% of those aged 30 years and over. A number of these older doctors may have come from graduate entry four-year degree programmes, as we know they have an older age profile. Table 22 shows how age, gender and ethnicity affect whether doctors feel they have the skills they need – we found a very similar pattern when we asked doctors whether they felt adequately prepared for their first foundation post.

TABLE 22: **Preparedness of UK graduates doctors by age, gender and ethnicity**

Number of doctros and % who agreed with the statement: 'The skills I learned at medical school set me up well for working as a foundation doctor'.

AGE (YEARS)	Male doctors				Female doctors				**Total**	
	BME		White		BME		White			
<30	72%	956	76%	1,815	71%	1,138	78%	2,636	**75%**	**6,545**
30+	74%	62	67%	187	59%	59	70%	238	**68%**	**546**
Total	**72%**	**1,108**	**75%**	**2,002**	**71%**	**1,197**	**77%**	**2,874**	**75%**	**7,091**

Ethnicity and place of primary medical qualification are independent predictors of success in royal college exams

As noted earlier, Woolf and colleagues' systematic review showed that BME ethnicity has a strong correlation with performance in postgraduate assessments.[72] Research on the Royal Colleges of Physicians, Psychiatrists and General Practitioners postgraduate training exams shows that ethnicity and place of primary medical qualification both affect the likelihood of a doctor passing their specialty or GP training exams.

The Royal College of Physicians found that, in 2002,[77] UK graduates were more likely to pass (67%) than non-UK graduates (26%), white UK graduates were more likely to pass (73%) than BME UK graduates (56%), and gender did not have a significant effect. More recent research on the exams taken from 2001 to 2011 showed that, while some examiners tend to give higher or lower marks across the board, there is no evidence of partiality by gender, and only one of 29 assessors showed evidence of partiality by ethnicity.[78]

The Royal College of Psychiatrists published data on its membership exams – three written papers and one clinical skills assessment – for 2008–10.[79] Overall, UK graduates outperformed non-UK graduates, and white doctors outperformed BME doctors, especially in the clinical assessment of skills and competences.

Looking more closely at breakdowns by place of primary medical qualification and ethnicity, graduates from southeast Asia outperformed other groups in the three written papers as a group, but performed poorly in the clinical skills assessment. Chinese doctors outperformed others for the three written papers, with white doctors achieving the highest pass rate in the clinical assessment of skills and competences. Female doctors were more likely to pass than male doctors in all areas of assessment.

In the independent review of the Membership of the Royal College of General Practitioners (MRCGP)[80] exam, 5,721 doctors took their first clinical skills assessment between November 2010 and December 2012 and had an identifiable ethnicity. Of those, BME non-UK graduates were 15 times more likely to fail than white UK graduates. For UK graduates, BME doctors were four times more likely to fail than white doctors at the first attempt.

This review also showed that ethnicity differences in pass rates were no longer statistically significant for non-UK graduates, if scores for the applied knowledge test, part 2 of the Professional and Linguistic Assessments Board test and the International English Language Testing System exam were taken into account.[81]

Implications of our findings

Collating and analysing the wealth of data about medical education are key to making fair and balanced judgements and developing initiatives that recognise the impact on doctors in training and on their patients.

Many medical graduates report not feeling fully prepared, although to some extent moving from academic study into a stretching work environment is inherently difficult to cope with. We are particularly concerned about some aspects of practice such as prescribing, coping in emergency situations, resilience, professionalism and employability.

Our data highlight that medical students leave medical school with variable perceptions of how prepared they are for working as a doctor. Work needs to be done to better understand how medical schools can improve preparedness, and to share best practice between medical schools.

Variation in the performance of doctors in training that is associated with any protected characteristic, including their ethnicity, is concerning and we need to take steps to understand this better.

Medical school graduates vary in their chosen careers as doctors – for example, some schools produce more GPs in training – which raises questions around why these doctors are choosing different specialties, and what medical schools need to do to create the right balance in the future medical workforce.

Tackling these shortcomings will involve addressing the realities of clinical environments and the expectations of employers and trainers, alongside considering the design, delivery, assessment and regulation of undergraduate education. Among the options that have been discussed is the introduction of a national licensing exam.

Chapter 4: Issues being raised to us by doctors and others in the UK

The state of medical education and practice in the UK reports have relied heavily on quantitative data both from the GMC itself and from other sources. In this chapter, we draw on qualitative information – what doctors and others choose to tell the GMC, as the national regulator, they are concerned about. We use examples and quotes from this qualitative information to illustrate the wider issues being raised to us.

The feedback comes through our liaison services across the UK and from the issues raised when people ask for advice on good practice (box 8). As these are the views of individuals and organisations, they are subjective, reflecting concerns at a point in time. Depending on how and when the concerns are raised, we may not know how widely their experiences or opinions are shared with others.

These data do, however, show the issues that some doctors say they wish to have additional support for (figure 57), and that they have concerns about. Though there is a selection bias, the data can indicate potential areas for further investigation to improve our understanding, help support doctors, and identify any impact on our work as a regulator.

Of particular concern for regulation are difficulties doctors describe in relation to raising concerns (pages 136–7). Over the last 18 months there has also been a strong sense that people speaking to us are feeling higher pressures at work than they feel they have experienced in the past (pages 137–140). Finally we examine four specific issues that have been particularly raised with us recently: end-of-life care (pages 142–3), conflicts of interest (pages 144–5) the use of social media (page 146) and confidentiality issues (page 147).

BOX 8: Sources of qualitative data

GMC liaison services

We have several teams that work with key individuals and organisations to improve how we work with doctors and other organisations. The aim of this engagement is to increase our understanding of the reality of work for doctors in the UK, and to enable us to learn from what is happening on the clinical and educational frontline. The feedback we receive through these teams can highlight trends, examples of good and poor practice, and concerns.

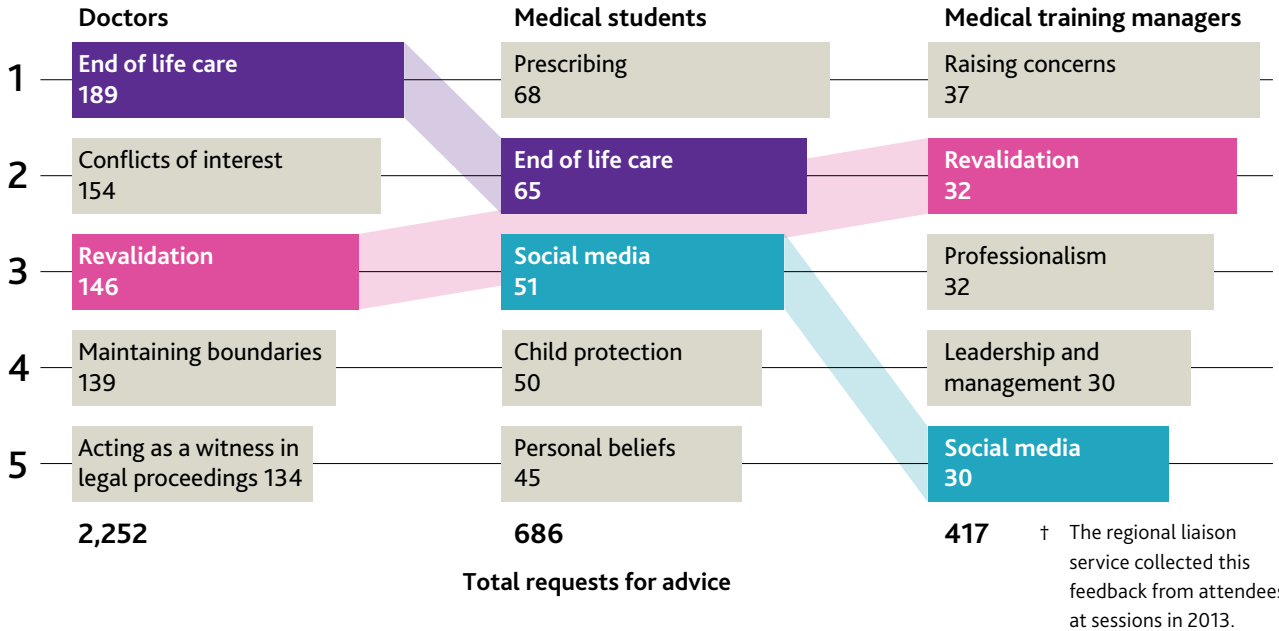
- Regional liaison service: eight advisers in England who work with doctors, medical students, patients and the public.
- Offices in Northern Ireland, Scotland and Wales: work with key individuals, groups and organisations in each country.
- Employer liaison service: 15 advisers in England, and one adviser in each of Northern Ireland, Scotland and Wales, who work with responsible officers,* employers and those who contract with doctors.

GMC standards team

The standards team responds to requests for advice on good practice from doctors, patients, those involved in medical education and training, and any other interested parties. These requests help us understand where we should focus our work to make sure doctors understand the standards expected of them.

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

FIGURE 57: Top five requests from doctors, medical students and medical training managers for future sessions to be run by our regional liaison service†



† The regional liaison service collected this feedback from attendees at sessions in 2013.

There remains a lack of awareness of how to raise concerns

All doctors, whatever their role, have a duty to act when they believe patient safety is at risk, or that a patient's care or dignity is being compromised.[82]

The Mid Staffordshire inquiry reinforced the importance of all healthcare professionals being able to raise concerns.[2] The evidence suggests that most doctors are aware of the need to raise concerns and know how to do so in their own working lives. However, feedback through the GMC's regional liaison service suggests that among some there is a continued lack of awareness and a feeling that they might not be supported were they to raise a concern. The standards team also receives regular requests for advice on raising concerns, and a confidential helpline for doctors has been set up – further information about this is shown on page 137.

Some local processes for raising concerns are difficult to navigate

Feedback from the GMC's regional liaison advisers suggests that doctors sometimes find it difficult to raise concerns through local processes.

For example, a group of second-year foundation doctors raised issues about inadequate staffing with consultants, but did not know what to do when their concerns were not addressed. GPs we have spoken to also did not know how to raise concerns. One local medical committee said it has often been approached by local practices about where to send a concern, but they did not know how to respond because the local process is not clear.

A recurring theme has been that existing processes do not give adequate feedback to the individual who has raised the concern, in particular about whether any changes have been made as a result. This is clearly contrary to GMC guidance, which states that the investigator must tell those who raised the concern what action has been, or will be, taken to prevent the problem recurring. It also runs counter to recommendation 12 of the Mid Staffordshire inquiry, which reminds employers that staff are entitled to receive feedback about any report they make, including information about any action taken or reasons for not acting.

Some doctors fear a lack of support when they raise concerns

Some doctors continue to report that they are not supported when they raise a concern.

This is not unique to the medical profession. The Whistleblowing Commission report[83] cites a YouGov poll from 2013 where a third of respondents reported not acting on a serious concern because of fear of reprisal and their colleagues' response. Furthermore, in a report by Public Concern at Work,[83] 74% of 1,000 whistleblowers said they were ignored when they first raised a concern.

Our 2014 national training survey asked doctors in training about raising concerns. We are analysing the responses and will be publishing the findings later this year.

Support for doctors who raise concerns

We have launched a confidential helpline for doctors who are concerned about patient safety and want advice about our guidance or feel they cannot raise their concern locally. Since launching the confidential helpline in December 2012, we have received 1,235 calls (to the end of April 2014). These calls have led to 191 complaints about the fitness to practise of 237 doctors, and have triggered 90 serious investigations.

In Scotland, the NHSScotland Confidential Alert Line formally began on 1 August 2014 and is run by independent whistleblowing charity Public Concern at Work.[84] This followed a successful year-long pilot in which the first 11 months saw 159 cases consisting of 90 public interest (whistleblowing) cases and 69 private or contractual matters.[85] Its staff are legally trained to give support and advice, as well as refer on cases to the appropriate body.[84]

The GMC's regional liaison service and offices in Northern Ireland, Scotland and Wales have also been running sessions on how to raise concerns. Following the sessions, some doctors said they were 'more aware of the need to reflect on practice and raise concerns', felt more confident in raising concerns, and were more likely to call the GMC confidential helpline for advice or to escalate concerns if they were not addressed.

We have also produced an interactive decision-making tool to guide doctors through the process of raising concerns.[86]

Pressures on primary and secondary care

The proportion of NHS spending on general practice in Great Britain* has declined in recent years from 10.3% of the British NHS budget in 2004–05 to 8.4% in 2011–12.[87] Between 1995 and 2008 the number of GP consultations has increased by an estimated 11% and the number of nurse consultations by 150%, largely thought to be a result of an ageing UK population and an increasing number of patients with long-term conditions.[88]

The feedback to the GMC's regional liaison services suggests that doctors working in primary care consider themselves to be under considerable pressure. There were differences between rural and urban areas, but there were common themes with concerns about being overloaded and some GPs being at risk of burning out.

The reasons behind this may be more complex than simply rising demand, but the perception of the doctors involved is not in dispute and there must be a danger that negative perceptions of general practice affect the number of doctors wishing to enter GP training. The number of applications has dropped from 6,031 to 5,100 since 2013 and there is considerable variation in the supply of trained GPs across different parts of the UK. While take-up of training places is as low as 62% in the East Midlands and a little over 70% in large parts of the north of England,[89,90] Northern Ireland has filled 98% of its training posts, Scotland has filled 89% and Wales has filled 90%.[89]

* Great Britain is England, Scotland and Wales.

Feedback from our sources shows primary care is under pressure. Our regional liaison team in England contact local medical committees and GPs frequently, and this frequent contact is one reason why we heard concerns about primary care frequently in 2013. Many areas of secondary care, including in psychiatry and emergency medicine, have also reported being under pressure to our regional liaison service and offices in Northern Ireland, Scotland and Wales.

In 2013, core psychiatric training in the UK filled only 75% of its places.[91] Since 2004, the Royal College of Psychiatrists and the Department of Health have worked to improve retention[92] by attempting to counter negative perceptions of the specialty. Some medical students see the specialty as being of low status and even unscientific,[93] but it has had some success in 2013 with more UK medical students showing an interest.[94] However, this coincides with increased worries that changes to visa rules mean international medical graduates (IMGs),* who often fill gaps in recruitment in psychiatry, might not be available to fill vacancies in the same numbers as previously.[95]

Likewise, in emergency medicine, the increase in demand has caused gaps in care provision. The College of Emergency Medicine calculated that, in October 2012, England alone needed 2,222 emergency medical consultants to meet demand, but that in the UK as a whole there were just 1,400.[96] Action has been taken in the form of a task force of royal colleges, the Department of Health and NHS Employers,[97] which agreed joint proposals to address shortages in December 2013. The Scottish[98] and Welsh[99] Governments have both targeted overseas doctors to fill the gaps in Scotland and Wales. In table 2 (page 50) we showed that the number of doctors in emergency medicine has grown by almost a third between 2010 and 2013 following a push in recruitment.

The independent Shape of Training review,[48] published in 2013, highlighted that the competition ratios for general practice (2.3 applicants per post) and some of the other more generalist specialties are much lower than for smaller specialties, such as medical microbiology and virology (5.1), public health (8.6) and a pilot of a specialty in cardiothoracic surgery (11.3).[100]

A lack of supply of primary care doctors is not unique to the UK – the US Accreditation Council for Graduate Medical Education is concerned that too few medical students are going into primary care and are instead becoming specialists.[101]

The different parts of the UK have recognised these problems. In England, the Government has created the £3.8 billion Integration Transformation Fund,[102] which is earmarked largely for primary care projects to prevent hospital admissions and is due to be made available in 2015–16.[103] In Scotland, the *Everyone Matters: 2020 Workforce Vision* report[104] commits the Government to strengthening the workforce. A Scottish Investment Plan is earmarked for development, alongside a national programme of actions for improved delivery, better use of data and an extended risk assessment model to identify areas of concern faster.[104] The Scottish Government is also looking at improving staff retention with an emphasis on designing working patterns to maximise the quality of clinical outcomes.[105]

* 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.

Pressures on primary care in urban areas of England

There has been a huge expansion in the GP workforce in recent years – the number of GPs in England grew by almost a third between 1995 and 2011, and the number of patients per GP reduced from 1,724 to 1,471 between 2000 and 2011.[106]

However, according to the Centre for Workforce Intelligence, there are many areas in England where demand for GPs outstrips supply – and these tend to be urban and deprived areas.[106] Prosperous, rural areas in England tend to find it easier to attract GPs,[106] although there are problems recruiting to regions of low population density across all four UK countries. In the six-year period to 2010, some primary care trusts in the northeast, northwest, north London, and West Midlands had vacancy rates of more than 10%, with Solihull at almost 20%.[107]

Feedback through the GMC's regional liaison service – from meetings with GPs and local medical committees across the Midlands and the north of England – suggests that there is continuing concern about the impact of a lack of capacity and a heavy workload.

GPs are covering wide geographical areas in Scotland

In 2011, Scotland had 0.95 full-time GPs per 1,000 patients, which compares favourably with the number in England and Wales.[108] But, as the population density is lower, some GPs are covering wider geographical areas with very small numbers of patients.[109]

The chairman of the British Medical Association (BMA) General Practitioners Committee for Scotland has this year identified similar recruitment challenges to those elsewhere in the UK.[110]

GP practices in Wales aren't able to recruit enough GPs

Wales has 0.66 full-time GPs for every 1,000 patients.[109] Feedback to the GMC's Wales office indicate that there is a continuing capacity problem in primary care, especially in rural areas.

The current growth in general practice in Wales was reported in 2012 by the Welsh Institute for Health and Social Care as being 'not strong enough to meet the predicted need', with a need to recruit 50 additional GPs per year to meet the predicted demand.[111]

These recruitment difficulties are being exacerbated by an ageing GP workforce. In Wales, there was a 42.1% increase in GPs aged 55 years or over during 2003–13.[112]

Stress and burnout

Doctors generally have higher rates of mental health problems – depression, anxiety, alcohol or drug addictions, burnout and suicide – compared with the general population.[113] Recent feedback to the GMC's regional liaison service suggests that levels of stress may be increasing.

BOX 9: Changes in healthcare services in the UK

In April 2013, following the introduction of the *Health and Social Care Act 2012*, clinical commissioning groups (CCGs) took over from primary care trusts to commission services in England. CCGs include GPs, at least one nurse and secondary care doctor, and lay representatives, with at least one GP on the board. CCGs commission certain community services, out-of-hours primary care and most secondary care, including which drugs and treatments to pay for and which hospitals patients should use.

The groups do not commission GP contracts and primary care services – this is the responsibility of local area teams run by NHS England. There are however proposals for co-commissioning, where CCGs join with NHS England local area teams to commission primary care services.

Ongoing concerns in Northern Ireland about the performance of emergency departments, voiced in the media by patients, politicians and healthcare professionals, have resulted in the Regulation and Quality Improvement Authority (RQIA) reviewing unscheduled care arrangements. The report was published in July 2014[5] and made recommendations to improve Belfast Health and Social Care Trust's acute medical unit, respiratory medicine, and care of the elderly. It also recommended improving coordination across hospitals within the trust. The Minister of the Department of Health, Social Services (DHSSPS) and Public Safety has recently announced a regional task group to take forward the RQIA's recommendations under the joint leadership of the chief medical officer and chief nursing officer.[114]

The Minister of the DHSSPS, Edwin Poots, has appointed Professor Sir Liam Donaldson, former Chief Medical Officer for Her Majesty's Goverment, to head a review examining governance arrangements in the health and social care sector in Northern Ireland. The review panel is due to report to the Minister by the end of 2014.[115, 116] A shortfall in funding in the health service in Northern Ireland remains a concern for the Minister and has been the subject of much public and political discussion. Minister Edwin Poots has highlighted his concerns about the impact on patient safety if he has to make a further £140 milion in savings in 2014–15.[117, 118]

The inquiry into hyponatraemia-related deaths has completed its evidence gathering phase and is expected to be published by the end of this year. It is likely to contain recommendations that will need to be taken forward in the health and social care sector.*

The Northern Ireland Health and Social Care Board, in partnership with the health and social care trusts and other providers, is continuing to implement the wide ranging recommendations from the *Transforming Your Care review*[119] that include changes to community, end of life, child and elderly health services, and some rationalisation of secondary care.

Scotland's 14 territorial boards are responsible for providing most health services in their areas, including primary care services through 34 local community health partnerships.† These boards will be working with local authorities in their areas to integrate health and social care services.[120] The Scottish Government recently consulted on relevant regulations and, at the time of publication, was analysing responses.

The Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire was published in late 2013.[121] The long awaited report of the inquiry into deaths from *Clostridium Difficile* at the Vale of Leven hospital is expected later this year, as is a report looking at the management of waiting lists at NHS Lothian.[122] And NHS Grampian has invited Healthcare Improvement Scotland to carry out a short independent review of the quality of care at Aberdeen Royal Infirmary.‡

Wales is reorganising how and where healthcare services are delivered, in line with the Welsh Government's *Together for Health* vision for NHS Wales.[57] This report highlighted some difficulties in training and staffing for certain specialties, and challenges meeting the needs of an ageing population with a rising number of chronic conditions.

The Welsh Government has also commissioned an independent review of Healthcare Inspectorate Wales,[124] following a cross-party inquiry into the watchdog by the Health and Social Care Committee.

* www.ihrdni.org

† A community health partnership is a committee of the health board that develops local community health services, with representatives from the territorial boards and local authority partners.

‡ www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme-resources/ari_review.aspx

Standards of end of life care

There have been serious concerns raised about the standards of care for patients in their last few days and hours of life. The independent review of the use of the Liverpool Care Pathway in England[125] produced disturbing evidence about the misuse of this decision-making tool, which was designed to help staff provide the right level of care for each patient. An audit of deaths in hospitals in England by the Royal College of Physicians and Marie Curie Cancer Care raised similar questions.[126] Both reports revealed poor communication with patients and their families, and the need for fundamental improvements in this area. Poor communication was at the heart of many of the problems with particular concerns noted around nutrition, hydration, pain management and decisions to attempt cardiopulmonary resuscitation (DNACPR).

End of life care across the UK

The Liverpool Care Pathway, a set of guidelines originally developed by the Royal Liverpool University hospital and the Marie Curie hospice in Liverpool, was developed to help non-specialist hospital staff give all people who are dying the same high-quality care that terminal cancer patients get in a hospice.

The review of the Liverpool Care Pathway in England has added emphasis to the already strong focus on end of life care in Northern Ireland, Scotland and Wales. There is a commitment to review and update palliative and end of life care strategies.

Northern Ireland: the Liverpool Care Pathway will be phased out by the end of October 2014. The DHSSPS has published five principles which should underpin the quality of care in the final days and hours of life in line with its Dying Matters Palliative and End of Life Care Strategy.[127]

Scotland: the Liverpool Care Pathway is due to be phased out by the end of 2014. The Scottish Government produced an interim statement in December 2013,[128] setting out the key principles for high-quality end of life care, and has committed to developing a framework for action on palliative and end of life care.

Wales: the *All Wales Integrated Care Priorities for use in the Last Days of Life*[129] is used instead of the Liverpool Care Pathway. The priorities continue to be reviewed each year to make sure they are accurate and relevant.

Although there have been specific challenges in end of life care, the UK continues to be a leader in this area. Developed in the 1960s, modern end of life and hospice care has been a relatively recent development in medicine,[130] led by the UK hospice movement.[131] One report ranks the UK as joint first with Australia in a comprehensive index for quality of death.[132]

Doctors want more guidance on end of life care

That end of life care is one of the most challenging areas of medicine is reflected in the requests for sessions from the GMC's regional liaison service in England. It was the most sought after session with 189 requests from doctors in 2013 (figure 57). Among medical students, it was the second most popular area of practice on which they wanted guidance after prescribing. In the feedback from these sessions, the doctors raised concerns about managing end of life care in the community, logistical difficulties of providing care outside hospital, and clinical accountability.

The GMC standards team also receives a large number of questions about end of life care issues. Queries include what is ethically and legally permitted when it comes to decisions about withdrawing or not starting treatments, the role of family members in making decisions, and challenges around joining up health and social care.

Improving doctors' communication with dying people

As noted in chapter 3, some doctors in training feel unprepared for communicating difficult issues, such as end of life decisions. The feedback to the GMC's liaison services suggests that even experienced doctors can sometimes lack the confidence and skills to communicate distressing issues effectively.

The GMC is working with those who deliver medical education and training to consider what changes may be needed to improve standards of end of life care. This will involve looking at the undergraduate and postgraduate curricula, the resources allocated to this area and the way it is taught. There is clearly a need to increase the emphasis on effective communication and shared decision-making skills, both of which are vital for helping patients who are approaching the end of life and their families. The GMC will also continue to hold sessions and discuss good practice on this topic with doctors, medical students, patients and patient groups.

Independent mental capacity advocates

There is one other area beyond end of life care where the challenge of supporting vulnerable patients has been highlighted – how and when to involve an independent mental capacity advocate (IMCA).[133] IMCAs were introduced following the *Mental Capacity Act 2005*,[134] which applies in England and Wales. IMCAs must be used by law when doctors are making a decision about serious medical treatment, but the patient lacks the capacity to make the decision and there are no appropriate family members or friends to consult. A House of Lords select committee, which scrutinised the *Mental Capacity Act 2005*,[133] welcomed the use of IMCAs and called for them to be more widely used. However, it also noted that some doctors regarded the IMCA service as bureaucratic and time consuming, while others did not know the service existed.

Balancing conflicts of interest is of concern to some doctors

Declaring interests on the register

Concerns about the quality of medical research[135] have driven a debate about whether (and how) doctors should declare their interests. Later this year, we will review the information we include in the medical register to explore ways of making it more accessible and more useful for patients, employers and doctors. As part of this process, we will begin to consider whether the medical register should contain a log of doctors' interests. Any proposals would need careful consideration, consultation and, ultimately, legislation.

In England, some doctors are concerned about commissioning and conflicts of interest

Since April 2013, many GPs in England have had new roles as commissioners (box 9, page 140). This appears to have increased anxiety about possible conflicts between doctors' use of public funds and their own financial interests in providing services. It also highlights tensions between their duty to use public funds in the interest of all patients, and their duty to each patient that they treat. In this context, there are particular concerns about the impact on standards of care where access to treatments are managed through third parties or restricted in other ways under local policies developed by commissioning groups.

As soon as the new CCG system was introduced, doctors considered conflicts of interest to be the biggest worry.[136] A *British Medical Journal* investigation found more than a third of GPs on the boards of CCGs have a conflict of interest due to directorships or shares held in private companies.[137] According to at least one CCG, many doctors are continuing to struggle with being both a commissioner and a provider.

According to NHS Clinical Commissioners, the membership body of CCGs, such conflicts may be overcome by strong oversight from lay members, working with local authority Health and Wellbeing Boards and with NHS England local area teams.[138] Each CCG is under a statutory requirement[139] to maintain a publicly accessible register of interests of the members of its governing body, employees and committees. CCGs are under an obligation to log conflicts as soon as they are raised, and to track how they manage each conflict that arises. Arrangements for managing conflicts of interest are written into CCGs' constitutions and they are designed to ensure that they do not affect the integrity of decisions made to award contracts. NHS England has produced guidance on managing conflicts of interest.[140] Monitor, the regulator for NHS foundation trusts, has also produced substantive guidance on procurement, patient choice, and competition regulations for CCGs.[141]

The GMC has produced a short document pulling together its professional guidance on conflicts of interest – this was published on 25 March 2013 and came into effect on 22 April 2013.[142]

Some local medical committees have suggested that the legal framework to deal with conflicts of interest is inadequate and at least one CCG has raised concerns about the bureaucracy involved in establishing measures to review conflicts of interests.

Feedback through the GMC's regional liaison service and requests to its standards team indicate that debates about financial interests and commissioning arrangements are continuing in England.

Doctors and patients have ethical concerns about commissioning

GPs, commissioners and patients have also raised specific ethical concerns, asking for advice from the GMC's standards team about:

- how funding decisions are made, by whom, and what criteria are being used
- the liability and accountability for complications arising from a procedure or treatment not being provided, who is responsible clinically and who is responsible for telling patients
- what action should be taken, and by whom, when CCGs refuse to fund a recommended treatment
- whether commissioners and service providers can offer or take incentives for managing referrals without being in breach of GMC guidance.

Guiding doctors on handling conflicts of interest

The GMC's core guidance *Good medical practice* states that doctors must be honest and open about financial and commercial relationships, and must not allow any interests they have to affect the way they prescribe for, treat, refer or commission services for patients.[142] As noted above, there is explanatory GMC guidance that sets out how doctors are expected to approach these situations.[142]

It should be stressed, however, that this is about managing conflicts of interest, not eliminating them. The new system of commissioning does not introduce any new ethical dilemmas but, for some doctors, it is likely to make those situations more acute and more common. The introduction of co-commissioning (box 9, page 140) is almost certain to have the same effect.[143]

Guidance cannot solve conflicts of interest, only clarify the obligations doctors face and what needs to be done about them. The GMC has been using its employer and regional liaison services to promote its guidance and help embed it into practice, but we will continue to review whether there is more we can do to support doctors with managing these situations.

Use of social media

Social media was one of the top ten topics covered by our regional liaison service in 2013 and medical students requested sessions explaining our guidance on this topic 61 times (figure 57, page 135). In these sessions, medical students and doctors expressed concerns about doctors using social media unguardedly, especially to voice how they are coping professionally, pressures on time, tiredness on the wards and making clinical mistakes. The Medical and Dental Defence Union of Scotland reported that calls from doctors about social media quadrupled between 2010 and 2012.

New ways of communicating present new challenges and opportunities for doctors. There have been many initiatives made possible by social media, such as NHS Change Day* and #meded,† and there are clear benefits to sharing certain kinds of challenges, information and support.[144] But the potential to blur the boundary between doctors' professional and personal worlds does present risks to their professionalism. The take-up of social media by medical students and doctors places them at greater risk of inappropriate communication. The use of social media by patients and the public to raise issues[145] also means that all doctors need to be aware of social media and the increasing role it will play in the doctor-patient relationship.

Unprofessional use of social media

There is increasing evidence of potentially offensive or damaging tweets and Facebook posts by doctors worldwide.[146] One US study[147] showed that, in 2008, around 65% of medical students and residents (doctors in postgraduate training) were already using Facebook. The study's authors stated that some users seemed unaware of, or unconcerned by, the possible ramifications of sharing personal information.

Researchers analysed 237 Twitter accounts held by Swedish medical students and doctors: 2% of the 13,780 tweets sent were deemed to be unprofessional. Of these, 26 included information that could violate patient privacy.[148]

There are widely used Facebook pages by and for doctors, which discuss patients and treatment in a humorous though not necessarily unprofessional way, as well as how to cope with training.[149]

In a study of 682 medical students in 2013, a quarter believed they had posted content that they later thought was unprofessional and should not be posted online. Some also reported asking to be untagged from others' content.[146] There have been anecdotal reports of inappropriate use, involving breaches of patient confidentiality on Facebook,[150] and irreverent tweets[151] that have led to further online discussion across Twitter, Facebook and blogs about the role of irreverent humour as both a coping mechanism and a potentially dehumanising narrative.[152]

* Changed date – NHS.uk

† See www.symplur.com/healthcare-hashdags/meded for further explanation.

Training doctors on using social media

The GMC published guidance on using social media in March 2013.[153] This made clear that standards of behaviour do not change because the individual is online – in that sense, communicating through social media is the same as communicating face to face or through other traditional media. A number of medical schools have strongly reinforced this message, recognising the danger to a new generation that has grown up in a world of instant communication. However, more probably needs to be done at medical school and during postgraduate training to make sure everyone understands the risks as well as the benefits of the digital world and social media in particular.

Protecting patient confidentiality and use of patient data

The GMC's standards team receives many requests for advice about how to protect patient confidentiality while allowing doctors to use or share patient information. The requests in 2013 included a range of issues:

- introducing integrated systems for capturing and sharing patient information, such as the care.data system in England
- the possibility of new legal duties on doctors to report child protection cases
- the duty under certain circumstances to report patients with medical conditions to the DVLA or the DVA (in Northern Ireland).

Dame Fiona Caldicott's independent review of information sharing in healthcare in England[159] has recommended information systems are governed by a number of principles: sharing should be justified, minimal and on a need-to-know basis; everyone accessing the information should be aware of their responsibilities and compliant with the law; and the duty to share information in the best interests of patients can be as important as the duty to protect patient confidentiality.

The work of the GMC's standards team and regional liaison service shows that there is a range of views among both doctors and patients on this subject, including whether:

- patients need to give consent for their information to be accessible through IT systems that are integrated across health and social care
- current GMC guidance strikes the right balance between sharing confidential information promptly where it helps a patient or can protect someone else from serious harm, and keeping information protected so patients are not discouraged from seeking medical help because of worry about who will be able to get hold of their sensitive information
- the public benefit of sharing patient information – to help us plan services, inform clinicians and develop treatments – outweighs the public benefit of maintaining a confidential health service.

In response to these concerns and other significant developments in information governance across the four UK countries, the GMC has started to explore the issue of confidentiality with key individuals and organisations. We are planning to consult on an updated edition of our guidance on this subject in 2015.

Conclusion

This is not a report about the GMC or even about its activities – it is an attempt to use some of the data and wider intelligence that we have, and which we encounter, to gain a better understanding of the opportunities to improve standards of medical practice.

This year's report reveals a medical profession that continues to undergo major changes in its composition, but which still serves the population of the UK well. It is a profession adapting to the challenges of a more demanding, transparent and data-rich world and to a far more stringent financial environment. For those concerned with research, policy and regulation, these changes also provide challenges, as well as considerable opportunities, for example, to develop a better understanding of where good practice thrives or where risks of poorer practice may lie.

Here we draw together some of the themes highlighted in this report.

How well does medical education prepare doctors for practice?

Overall the evidence suggests that the UK should be proud of the education provided in its 33 medical schools. British doctors are respected and sought after in many countries and have a high reputation for quality.[61]

Ensuring high quality in undergraduate education is imperative. This year's annual national training survey[155] of doctors in training was reassuring – most doctors in the first year of foundation training (F1 doctors) felt that their medical school had prepared them to work effectively as a doctor, while the number who felt they were facing situations beyond their competence or experience has fallen materially over the past five years. These improvements are almost certainly the result of changes that medical schools have made in recent years (see chapter 3).

Concerns about prescribing

However, F1 doctors continue to be concerned about some aspects of their competence, particularly how to prescribe properly. This is the topic most requested by medical students to discuss with our regional liaison service (see figure 57, page 135). Accurate prescribing is critical for patient safety and, although the number of prescription errors that lead to harm is low, more needs to be done to make sure F1 doctors are adequately prepared to prescribe.

We are continuing to work with the Medical Schools Council and the British Pharmacological Society to develop a prescribing safety assessment. We will also now consider whether further initiatives need to be taken to enhance preparedness and confidence in UK graduates.

We need to better understand variations between medical schools

We have published data this year on the variation between medical schools, each of which has its own curriculum and assessment system. In this report, we have shown variations in the preparedness of medical students for practice, and the specialties that medical students go on to work in. There is also some suggestion, albeit from one year's data, that medical students who feel unprepared by their education are more likely to be given unsatisfactory outcomes in their annual review of competence progression (ARCP) scores – these are the reviews they are given during training. Care will be needed when interpreting these findings, but it is an area that deserves further analysis.

In future, we plan to publish data by medical school on what their graduates choose to do when they finish the Foundation Programme and on their subsequent performance in specialty exams. Through this additional data, we hope everyone involved in medical education will gain a better understanding of why students at one medical school perform better or worse than others when they start practising as doctors in training. In time, it should be possible to establish whether there is a link between this and how effective they are as doctors.

One difficulty is that what is considered poor, acceptable or even good in terms of variation by medical school is as yet little understood – there are complex relationships between the setting of standards and the activity needed to meet those standards.

Those concerned with workforce planning also need to consider what motivates students to choose their future specialties, and what could help create the right balance of medical skills for the future.

Movement of doctors around the world

Modern medicine is global: we benefit from the skills of doctors from around the world and other nations benefit from doctors trained in the UK.

Doctors joining and leaving the medical register are coming from and going to different countries than before

Our analysis shows changes in where doctors are coming from to work in the UK and, to a lesser extent, in where UK graduates are choosing to work. Once, the main source of non-UK graduates was south Asia, particularly India, and to some extent the Middle East and Africa. Now, a third of the increase in non-UK graduates are from southern European countries.

We do not know all the reasons for these changes but some are already clear – after changes to immigration rules in 2010, it became harder for international medical graduates (IMGs)* to secure training and employment here. The data suggest that the economic downturn in the European Economic Area (EEA), and the increased opportunity for EEA graduates in the new member states to work in the UK following enlargements in 2004 and 2007 are the main reasons for the increase in the proportion of EEA graduates working here.

* 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.

Among UK graduates who choose to work overseas, a considerable number still move to Australia and New Zealand, although the most recent data show a slight drop. A higher proportion are going to work in Hong Kong, Malaysia and Singapore, but the numbers going to these places are still fairly small.

The increasing proportion of EEA graduates has important implications

Data from our national training survey, fitness to practise processes and the small study of MPTS panel hearings in this report all indicate specific issues about EEA graduates. For example, GPs aged 30–50 years who were EEA graduates were nearly three times more likely to receive a sanction or a warning during 2010–13 than those who were UK graduates. And, among specialists and doctors not on the GP or Specialist Register who were over 50 years old, EEA graduates were more than twice as likely to receive a sanction or a warning than UK graduates.

Recent changes in legislation mean that, since July 2014, we have been verifying EEA graduates' language skills before they can begin working in the UK. This is intended to help prevent future problems stemming from an insufficient grasp of the English language. Together with government, employers and the medical profession, we will need to consider if further support for EEA graduates coming to work here would be effective.

The importance of EEA graduates in the medical profession should not be overemphasised – IMGs still make up the dominant number of non-UK graduates. The data in this report show that IMGs also face higher risks of being in our fitness to practise processes than UK graduates; regulators, the medical profession and policy makers need to consider if further targeted support for these doctors could be effective in tackling this. Following data in previous issues of this report, we piloted our welcome to UK practice sessions to support both IMGs and EEA graduates starting to work in the UK. Following the success of these sessions, we will be rolling them out across the UK in 2015.

Ethnicity seems to affect doctors' progress and their involvement in our fitness to practise processes

The vast majority of IMGs are black and minority ethnic (BME)* doctors, and BME doctors represent 17.4% of UK graduates.

BME doctors' progress through medical education and training

BME doctors underperform in medical school, even when their performances are adjusted for socioeconomic background and grades from secondary education.[71] This is not confined to medicine and indeed is reflected across higher education.[73] The data in this year's report show that F1 doctors who are BME are less likely to say they felt prepared by their medical school for practice. The GMC, the medical royal colleges and other partners have all made it clear that they are committed to understanding better the causes of differential attainment, which is linked not only to ethnicity, but also to gender and other characteristics. An important step will be to collate exam results across the specialties and consider what they indicate about the patterns in attainment. This work has now begun.

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

Ethnicity of doctors involved in our fitness to practise processes

The numbers of doctors who are investigated for fitness to practise issues are relatively small, and the numbers who receive a sanction or a warning are smaller still. Nevertheless, to make sure the process is as fair as possible and that any areas of risk are identified, it is important to identify patterns in who is affected and why. Perhaps most startling, we found that BME doctors aged 30 years and over who are not in training are more likely to be complained about, to have the complaint investigated and to receive a sanction or a warning than their white counterparts; this was found for doctors on the GP Register, Specialist Register, and those on neither register.

BME UK graduates are nearly twice as likely to receive a sanction or a warning than their white counterparts. The overall difference by ethnicity is therefore not just because proportionately more IMGs are BME doctors.

Our more detailed analysis in chapter 2 showed that some of this difference may relate to the source of the complaint:

- a higher proportion of BME doctors are complained about by employers than white doctors (11.3% versus 6.3%)
- 42% of complaints from employers are about BME doctors but only 28% of complaints from the public are about BME doctors.

Some of the differences may also relate to the categories of allegations involved in the cases. In particular, male BME doctors have more cases than white doctors that relate to criminality – these cases are much more likely to lead to a sanction or a warning. There are also differences in the degree to which different groups demonstrate insight or engage with the process through attendance and representation at panel hearings.

We will continue to look at our processes and to understand these issues better and to identify ways to support doctors in our fitness to practise processes. It is clear that further research is needed, looking specifically at what is driving differences by ethnicity, and whether any of the causes could be effectively addressed by intervention from us, from others engaged with the medical profession or from wider policy makers where the causes are more societal than specific to medicine. We are developing future plans for research in this area, building on the findings and issues raised in this report, and we will give our findings in future editions of this report.

Doctors on the Specialist Register

Chapter 2 shows that different specialties have different rates of complaints, warnings and sanctions. In this year's analysis, it has become clear that this has more to do with the nature of the specialty than with the demographic characteristics of the doctors. Three specialties – psychiatry, obstetrics and gynaecology, and surgery – had the highest risks of doctors being complained about and receiving a sanction or a warning. By contrast, pathology and anaesthetics and intensive care medicine had the lowest proportion of doctors complained about, and medicine and paediatrics had the lowest proportion of doctors who received a sanction or a warning.

This is likely to be due in part to the nature and volume of interactions between doctor and patient, the risk and transparency of the procedures involved and the sensitivity of the work being done. By understanding why different specialties present different risks, it may be possible to identify preventive measures or guidance in these areas.

One specialty, cosmetic surgery, has caused increasing concern in recent years as the number of procedures has grown and a succession of scandals has revealed vulnerable patients being subjected to poor standards of care.[25] We found that cosmetic surgeons are complained about more than other surgeons, and are nine times more likely to receive a sanction or a warning. Added to this, cosmetic interventions are undertaken by a variety of professionals, not just doctors, and even surgery can be performed by people who are not surgeons. Following Sir Bruce Keogh's review,[25] the Department of Health in England and the Cosmetic Surgery Interspecialty Committee are now considering whether only doctors on the Specialist Register should perform cosmetic surgery, and then only in their areas of specialty. At the same time, patients affected by poor care in cosmetic surgery may not be complaining to regulators in every instance, and this needs to be studied further. It may be that patients receiving cosmetic treatments need to be made more aware of the GMC and other healthcare regulators.

More data needed on locums

Introducing revalidation has offered the opportunity to gain a better understanding of locum practice in the UK and to make sure that locum doctors, as in all other areas of medicine, are competent and fit to practise on a regular basis. But it is fair to say that a great deal is still not known about these doctors. Even though many are now attached to a locum agency for revalidation, many are not – instead they have connected to their most frequent recent employer. There are also doctors who have a main employer but do some additional work as a locum.

Many locum doctors provide excellent care for patients, and healthcare services throughout the UK rely on them to fill gaps and, in some cases, to give specific specialist knowledge. However, there have long been concerns[156, 157] about the governance arrangements to support these doctors, and whether employers and other doctors can identify and act on any shortcomings in their practice. The Department of Health in England has been reviewing the oversight of locums. We will continue to work with locum agencies in their new role as designated bodies for revalidation, and we will report on progress as revalidation takes hold.

In the meantime, our data on doctors who do have a locum agency as their designated body for revalidation, mainly in secondary care, suggest that these doctors are more likely to be complained about and to receive a sanction or a warning than other doctors.

Some groups are more likely to receive a sanction or a warning because they are prone to particular types of allegation

As a doctor, the first rule – do no harm – might lead to the assumption that the most serious mistake a doctor could make would involve clinical competence affecting a patient. In one sense that is true. However, our fitness to practise process, as designed by Parliament, is strongly geared towards reducing future harm, rather than punishing doctors for past clinical errors. It therefore includes an assessment of the doctor's ability to show insight, improve their skills, and be open and honest. These factors are taken into account, in addition to the seriousness and nature of the incident, when deciding the outcome of a case.

It is often easier for doctors to show insight in a case involving clinical competence, where they can clearly show improvements in skills and evidence of reflection and learning. This may partly explain why our analysis shows that cases involving health issues (including substance abuse and mental and behavioural issues) and criminality, not those involving clinical competence, are most likely to lead to a sanction or a warning – which to some might seem counterintuitive.

Some groups of male and older doctors, non-UK graduates, BME doctors, those working in some specialties and those attached to a locum agency are more likely to receive a sanction or a warning. The different categories of allegations involved in the cases accounts, to some extent, for these differences in risk. Most notably, more cases about BME doctors and non-UK graduates involve types of allegation that are more likely to lead to a sanction or a warning.

These findings suggest that some groups are more likely to receive a sanction or a warning because they get into difficulty in particular areas, not because there is a general tendency for them to have more investigations of all types. In other words, a large part of the higher risk for a particular group, such as BME doctors, is linked to the specific types of allegation reported to us in relation to that group.

Although it may not be possible or easy to intervene in some areas, it may be possible to offer targeted preventive support. As mentioned earlier, we are rolling out our welcome to UK practice sessions for non-UK graduates in 2015, and our regional liaison service will continue to run sessions to tackle the types of difficulties that these groups seem to have.

What do we expect of doctors?

Doctors are under huge pressures from the changing environment in which they work. Some pressures will have to be addressed by the wider health system or indeed by society as a whole – for example, through restructuring and achieving the right level of funding. There are also longer-term trends that will have far reaching effects on medical practice. The ageing population is changing the balance of skills needed to deliver good care in the community, with implications for what training we should put in place, as outlined in the recent Shape of Training review.[48] New communications technology is potentially altering the way healthcare services can be delivered. Lifestyle expectations are changing and the decisions doctors make regarding work-life balance will be increasingly different from historical norms.

All this begs the question: what should we expect from doctors in the 21st century?

In the coming year we will return to the question of what professionalism means in a modern context. Given the current pressures on all branches of the medical profession and the wider healthcare system, there is a need for a clear debate about how healthcare professionals need to respond to changing demands, what skills and behaviours will be needed by the next generation of doctors, and what can justifiably be expected from them.

A note on data

Data in this report were primarily drawn from the information we collect when registering doctors and assuring the quality of medical education and training, and from the information we collect when assessing doctors' fitness to practise.

Where inferences and comparisons are raised in the text, these are statisticaly tested and were significant at the 95% level ($p<0.05$) except where indicated.

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

Data for the analysis of the profession in 2013 refer to the medical register (known as the *List of Registered Medical Practitioners*), the GP Register and the Specialist Register on 31 December 2013. Data for the analysis of the change between 2010 and 2013 refer to the state of the registers on 31 December of each year between 2010 and 2013. Where data are aggregated over 2010–13, the number of doctors are taken as being the average number of doctors over those years.

In most 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. Total doctor numbers, however, generally include these doctors.

The analysis of joiners and leavers was based on our records of doctors who joined the medical register between 1 January 2013 and 31 December 2013 inclusive.

Fitness to practise data

Fitness to practise data for 2010–13 was for enquiries received between 1 January 2010 and 31 December 2013. The data were drawn from the GMC's database on 3 June 2014. For data referring to specific years, we used enquiries received between 1 January and 31 December of that year.

We presented fitness to practise data by the year when the enquiry was received. A substantial proportion of complaints that originated in 2013 and were investigated did not yet have an outcome when the data were drawn from the GMC database: 1,289 complaints (42% of all investigated complaints).

Education data

Data about medical students by academic year between 2010 and 2013 came from the medical schools' annual reports to us.

The number of doctors in postgraduate training programmes was estimated using data that local education and training boards in England and deaneries in Northern Ireland, Scotland and Wales provided in the 2014 national training survey – it was accurate on 26 March 2014. It included some doctors who were not in a training post on 26 March 2014, and so included those taking a career break or maternity leave.

The 2014 national training survey was open from 26 March to 8 May 2014. Doctors in training were asked about the post they were in on 26 March 2014. 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 spcialties.

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. Older terms were matched where possible. However, 0.4% of doctors (254 doctors) whose primary specialty was not matched were grouped in the 'other' category.

Data relating to the age of a doctor

There is a small group of doctors on the register with no date of birth recorded (2.3% in 2010 and 1.9% in 2013). In these cases, age was approximated by adding 25 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 or mixed ethnic groups. We did not know the ethnicity of 19.5% of doctors on the register in 2013.

Regional and country data

The number of doctors per 100,000 people was derived using a denominator based on mid-2013 population estimates from the Office for National Statistics in the UK.[158]

In table 3 page 54, countries are grouped into regions using the following groups:

Africa: Algeria, Angola, Burundi, Cameroon, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Libya, Malawi, Mauritius, Morocco, Nigeria, Sierra Leone, Somalia, South Africa, Sudan, Tanzania, Togo, Tunisia, Uganda, Zambia and Zimbabwe.

Central Europe, eastern Europe and Baltic countries (EEA): Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland and Slovakia.

Northwestern Europe (EEA): Austria, Belgium, Denmark, Finland, France, Germany, Iceland, Ireland, Netherlands, Norway, Sweden and Switzerland.

Southern Europe (EEA): Greece, Italy, Malta, Portugal, Slovenia, Spain and Romania.

Non-EEA Europe: Albania, Belarus, Bosnia And Herzegovina, Croatia, Moldova, Macedonia, Russia, Serbia and Ukraine.

Middle East: Bahrain, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian Territories, Saudi Arabia, Syria, Turkey, United Arab Emirates and Yemen.

South Asia: Bangladesh, India, Nepal, Pakistan and Sri Lanka.

Rest of Asia: Afghanistan, Armenia, Azerbaijan, Georgia, Hong Kong, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Malaysia, Myanmar, Philippines, Province Of China, Singapore, Taiwan, Thailand, Turkmenistan, Uzbekistan and Vietnam.

Northern America: Canada and USA.

South, Central and Latin Americas and the Caribbean: Argentina, Barbados, Bolivia, Brazil, Cayman Islands, Chile, Colombia, Cuba, Dominica, Dominican Republic, Ecuador, Grenada, Guatemala, Guyana, Haiti, Jamaica, Mexico, Netherlands Antilles, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Trinidad and Tobago, Uruguay and Venezuela.

Oceania: Australia and New Zealand.

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