

# The **impact** of our work

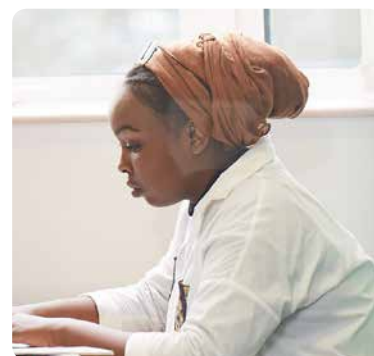
General  
Medical  
Council





## CONTENTS

<b>Foreword</b>	<b>02</b>
<b>Protecting the safety of the public and supporting the medical workforce</b>	<b>05</b>
Working with partners to make online prescribing safer	06
Protecting the public through robust registration checks	07
More flexibility and choice for candidates taking the PLAB 1 exam	08
<b>Working with doctors to maintain and improve standards</b>	<b>11</b>
Our app is helping to make standards more accessible	12
Providing support to international doctors	13
How we helped amend Scotland's Apologies Act to support proportionate regulation	15
<b>Assuring the quality of medical education and training</b>	<b>16</b>
National training surveys: taking action to support learners	17
How enhanced monitoring helps to maintain training standards	18
Using student engagement to highlight probity issues	20
New standards to make postgraduate training more flexible for doctors	22
<b>Sharing intelligence and collaborating with partners</b>	<b>24</b>
How data sharing can support collaboration	25
UKMED – the database that is boosting workforce planning	26
<i>The state of medical education and practice in the UK</i> report – pointing the way forward	27
<b>Delivering responsive and proportionate regulation</b>	<b>33</b>
How provisional enquiries are reducing regulatory pressure	35
Doctor Contact Service is helping to reduce stress of hearings	36
Supporting doctors experiencing health-related issues	37
<b>Conclusion</b>	<b>39</b>





## FOREWORD

# We are the independent regulator for doctors in the UK.

Our primary mission is to protect patients.

We do that by setting the standards for all doctors working in the UK, and by working with doctors to embed these standards in to their practice.

As part of our work we oversee medical education and training. And we take action when doctors or training and education providers fall seriously and persistently short of our standards.

And just as doctors need to be accountable for their practice, so we must also be accountable for what we do.



## How do we have impact?

We have impact in many different ways. This report describes some of them, focusing on our impact over the course of 2017.

The report is structured around five main themes:

- 1 Protecting the safety of the public and supporting the medical workforce**
- 2 Working with doctors to maintain and improve standards**
- 3 Assuring the quality of education and training**
- 4 Sharing intelligence and collaborating with partners**
- 5 Delivering responsive and proportionate regulation**

It shows how we helped address workforce issues by supporting international doctors intending to join the register and practise in the UK. It also shows how we contributed to improving the environments in which doctors are trained, and substantially reduced the numbers of full fitness to practise investigations by introducing provisional enquiries.

You should read this report in conjunction with the GMC and MPTS 2017 annual reports, which contain more general information about our activities and performance over the past year.

## How do we collaborate with others?

We can only have positive impact on public safety and on the work of doctors, educators and employers by working closely with others in the UK's healthcare systems.

We have invested in our data and insight capabilities to be able to increasingly target our regulatory efforts based on evidence in collaboration with others.

We collaborate in particular on data sharing, policy development, harm reduction and legislation. We have invested in our data and insight capabilities to be able to increasingly target our regulatory efforts based on evidence in collaboration with others. And we work with others to support and promote public safety and good medical practice more generally.

Collaboration is also a key part of being a learning organisation. We consistently make a point of gathering feedback on our activities, whether through strategic relationships, consultations, frontline engagement or research. We listen keenly, learn from what we hear and then react and adapt our regulatory work accordingly, striving to make it as responsive and proportionate as possible – while making sure the public is protected and safe.

## Our strategy

We have come to the end of our 2014–17 corporate strategy, having learnt much about the state of medical education and practice in the UK and having done much to improve it.

We have to be released from the shackles of an outdated legal framework that hampers our ability to create a more flexible model of regulation that is fit for the 21st century.

Our new corporate strategy for 2018–20<sup>1</sup> builds on this and on what we have learnt in recent years – both about what we are doing well and what we can improve on.

We want to continue to work more effectively with others by sharing our data and research more widely, supporting doctors and the public and streamlining our regulation processes even further. And we want to become even better at using our data and insight capabilities to prevent harm.

For this work to be successful, we need fundamental legislative reform. This would allow us to shift our focus towards promoting good medical practice, and using our data to identify and act on emerging risks to patients and education and training environments.

We have campaigned for legislative change for many years. We have to be released from the shackles of an outdated legal framework that hampers our ability to create a more flexible model of regulation that is fit for the 21st century and meets the needs of doctors, other health professionals and the public, and our ever-developing health services.

In the meantime, we will continue to work with doctors, patients and other partners in the UK's health services, playing our part in maintaining and improving standards in medical education and practice, speaking out when we have evidence that public safety is at risk, and learning from our experiences to continuously improve what we do.



**Professor Terence Stephenson**  
Chair of Council



**Charlie Massey**  
Chief Executive and Registrar

<sup>1</sup> See [www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/corporate-strategy](http://www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/corporate-strategy)



## Protecting the safety of the public and supporting the medical workforce

Protecting the safety of the public is our primary responsibility. That means taking firm and timely action where there have been serious failings in medical practice. But it also means working with doctors to support them – because if doctors are well supported they are more likely to give patients the best possible care.

In 2017, our Regional Liaison Service in England and our liaison advisers in Scotland, Wales and Northern Ireland engaged with over 26,000 doctors and over 23,000 medical students and educators across the UK.

In 2017 we engaged directly with over **26,000** doctors and over **23,000** medical students and educators across the UK.

This service plays a key part in raising awareness and understanding of our standards to support excellence in medical education and practice. A consultant who attended the *Duties of a doctor* sessions offered by the service said, 'it helped me gain insight into how I can empower and enable junior doctors to speak up, raise concerns and be more involved'.

We also introduced a number of changes to our support scheme for doctors or members of the public who appear as witnesses at medical practitioner tribunal hearings. These include increasing phone communication and keeping in touch on a more regular basis.

And we held over 500 meetings or phone conversations with patients or members of the public who had made a complaint about a doctor's fitness to practise. Feedback about our Patient Liaison Service<sup>2</sup> shows that most are very satisfied and that it has made the whole experience easier for them.

The following case studies show in more detail the impact that our work to support patients and doctors can have, directly or indirectly, on the safety of the public.

## Working with partners to make online prescribing safer

Online and remote prescribing – whether by phone, Skype or website – has become increasingly popular in recent years and offers many benefits. But it is also open to abuse, and we have come across examples of very poor practice where patients' safety is put at risk.

Prescribing was the second highest topic of interest when doctors emailed or phoned us for standards guidance.

Our guidance makes clear that a doctor's obligations are the same whether prescribing remotely or face to face,<sup>3</sup> and that doctors should only prescribe when they know enough about the patient to be satisfied the medicines meet their needs.

In 2017 we worked collaboratively with other regulators across the UK's healthcare systems to highlight the extent of the problems associated with remote/online prescribing, and share what we have learned with the wider medical community. We signed a joint statement and a letter<sup>4</sup> to online care providers and this united front is already bearing fruit.

<sup>2</sup> See [www.gmc-uk.org/concerns/information-for-patients/how-we-handle-concerns/support-for-patients-and-complainants](http://www.gmc-uk.org/concerns/information-for-patients/how-we-handle-concerns/support-for-patients-and-complainants)

<sup>3</sup> See [www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/remote-prescribing-via-telephone-video-link-or-online](http://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/remote-prescribing-via-telephone-video-link-or-online)

<sup>4</sup> [www.cqc.org.uk/news/releases/care-quality-commission-advises-people-take-care-when-using-online-primary-care](http://www.cqc.org.uk/news/releases/care-quality-commission-advises-people-take-care-when-using-online-primary-care)



For example, during 2017 the Care Quality Commission (CQC) flagged up concerns about unsafe prescribing in relation to a number of online primary care providers. We worked with the CQC inspection team to clarify points of our guidance, and they referred a number of doctors to us. As a result of this collaborative work, the CQC found improvements when it re-inspected providers in March 2018.

We now hold regular forums where the main regulators and online providers meet. We also attend monthly inter-regulatory meetings on the topic, coordinated by the CQC.

Doctors operating online also increasingly prescribe to patients in other countries via a website or video link. This also carries risks, which we discussed with other European regulators at a meeting of the European Network of Medical Competent Authorities in May 2017.

## Protecting the public through robust registration checks

The public needs to be confident that all doctors on the register are properly qualified to do their job. For this reason we have robust systems in place to make sure that every registered doctor is who they say they are and that they have the right qualifications to practise medicine.

Two years ago we received an application to join the register from someone claiming to be a doctor who had qualified in another European country. We have a thorough checking system and work closely with other regulators to verify qualifications, and, in this case, our suspicions were raised by the information we received.



In 2017 we granted registration to **20,623** doctors.

We also learnt that the applicant was currently working in a non-clinical position at a provider in England but was applying to take up a medical post. One of our employer liaison advisers raised our concerns regarding the individual's qualifications and experience with the provider. Following an internal investigation, the individual's contract was terminated.

As a result of the work by the provider and ourselves, we were able to produce a case file about the individual, which we submitted to the police. In 2017 the case was brought to court, the individual pleaded guilty to fraud and was sentenced to 15 months' imprisonment.

The case shows not only that our systems for spotting registration fraud are robust, but that by working in partnership with others, we can help to make sure that people who seek to cheat the system are exposed for what they do.



## More flexibility and choice for candidates taking the PLAB 1 exam

The PLAB (Professional and Linguistic Assessments Board) exam<sup>5</sup> is the main route through which doctors who qualified outside the European Economic Area or Switzerland can join our register and practise in the UK. In recent years demand to take the first, written part of the test has been growing, with many of our exam centres around the world reporting they are at capacity or even oversubscribed.

In 2017 we conducted a full review, which has led to a 34% increase in our annual assessment capacity – from 2,978 to 3,978 exam places.

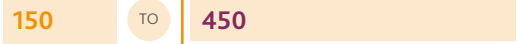
<sup>5</sup> See [www.gmc-uk.org/registration-and-licensing/join-the-register/plab](http://www.gmc-uk.org/registration-and-licensing/join-the-register/plab)

### Increases in Lagos were as follows:

November 2016



March 2017



November 2017



The review showed there were particular issues in our one UK centre in London, where demand always outstrips supply, and West Africa has only one location, Lagos in Nigeria, which is heavily oversubscribed.

As a result from November 2017 we increased our annual capacity in Lagos from 450 to 1,000 places. We also added three new centres – in Accra, Ghana; in Toronto, Canada; and in Sydney, Australia.

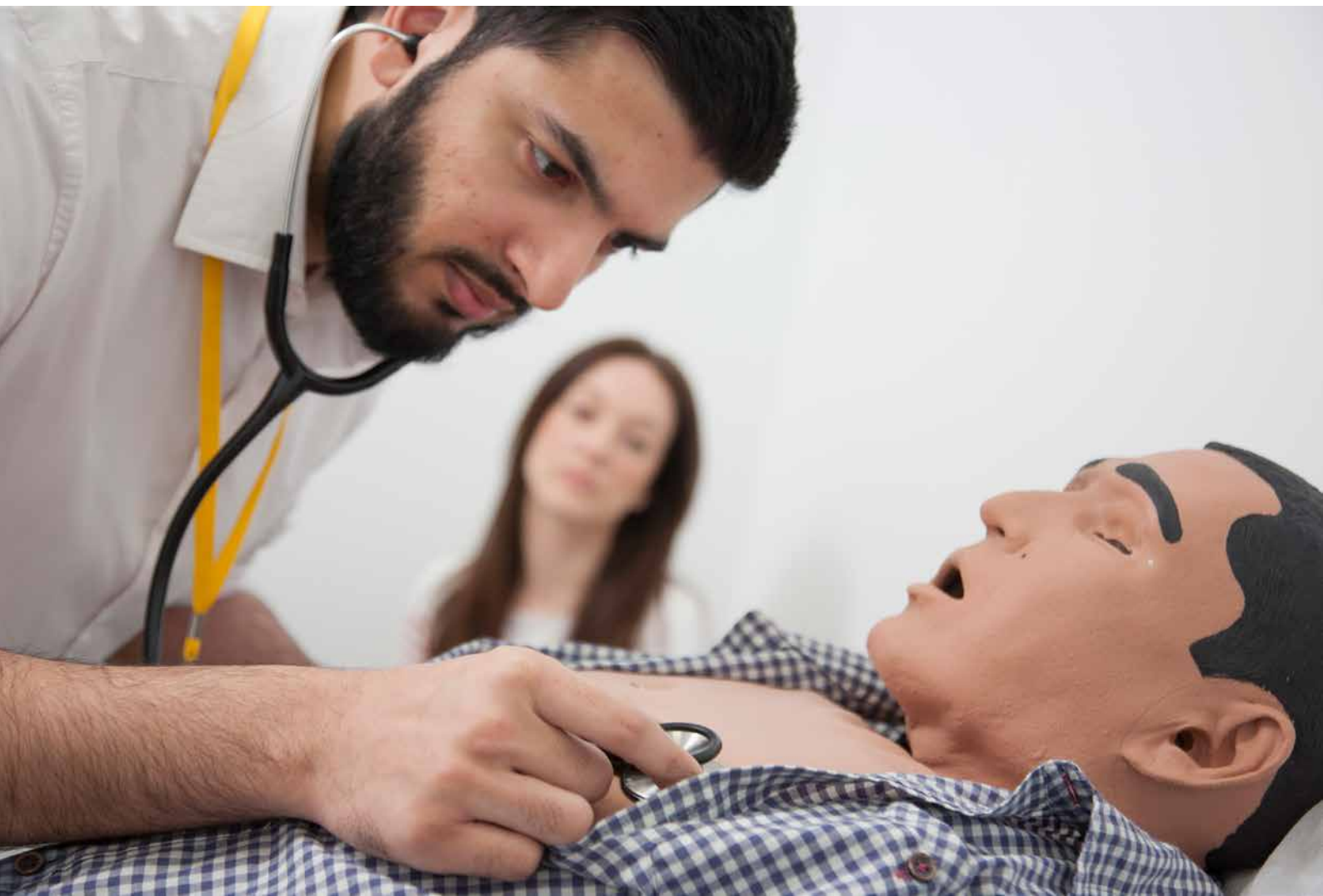
And we opened a new centre in Manchester for candidates sitting the test in the UK. This has capacity for 225 people a year, which will ease the pressure on our London venue.

The changes, which have proved extremely popular, mean we have been able to offer candidates far more flexibility and choice while maintaining demand for the exam. And by enabling more people to be assessed and eventually access practice in the UK, we are helping to address workforce shortages that are likely to become more pressing following our expected departure from the European Union.

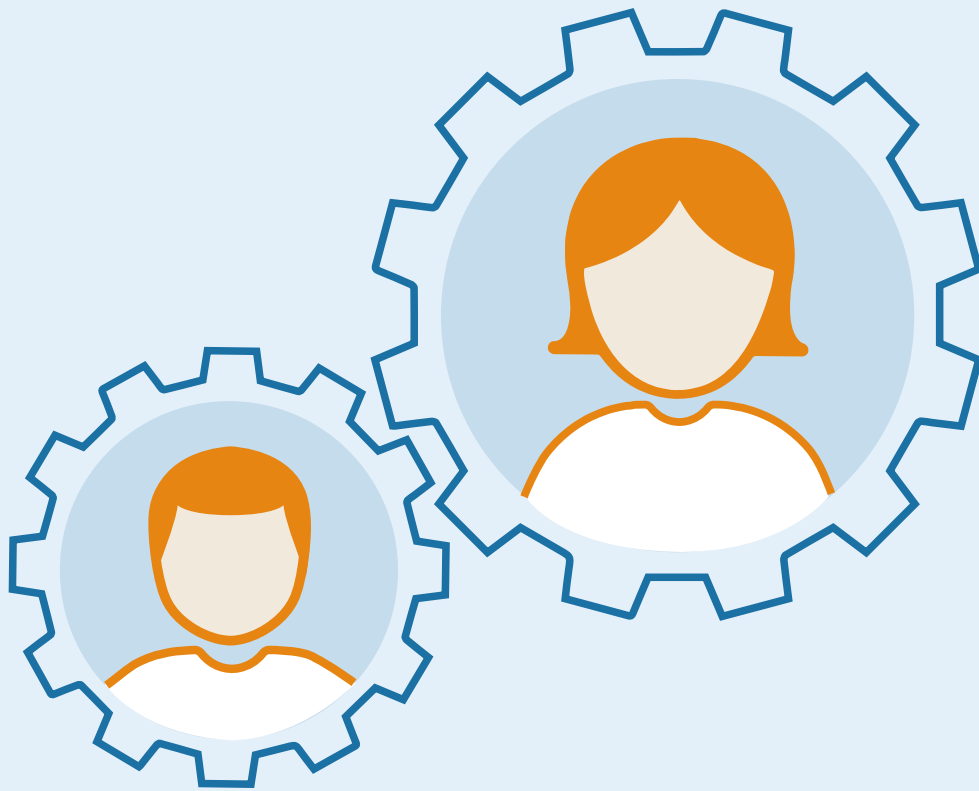
As these case studies illustrate, we're seeking to shift our emphasis away from acting when things have gone wrong to preventing harm happening in the first place. At all times we work to make sure the needs of patients and doctors sit at the heart of everything we do.

Over the next three years we aim to:

- develop processes that help us identify and better understand how and why patients or doctors come to harm. We will set up pilots on different themes of identified harm such as doctor-patient communication failures
- enhance the ways in which we engage with doctors and patients to understand their views and experiences and shape our work accordingly
- have greater assurance about doctors' capabilities when joining the register and at each stage of their careers, to meet the needs of patients
- provide more guidance and support to help people understand how best to get their concerns addressed and when to complain to us or to another organisation.







## Working with doctors to maintain and improve standards

Every patient should receive a high standard of care.

Our role is to help achieve that by setting the standards all doctors need to follow and working with them, and with others, to embed them into medical practice.

We work in many different ways to make this a reality. We engage directly with doctors to promote our guidance, we work to influence policy and we provide learning materials to support the use of these standards in daily practice, including through our mobile apps.

“Extremely helpful and informative and completely answers my concerns. Thank you very much.”

”

Feedback from doctors using our ethical guidance enquiry service.

In 2017, for example, we ran a Welcome to UK practice<sup>6</sup> session for over 20 refugees and asylum seekers looking to work as doctors in Scotland. The aim was to promote our guidance, explore some of the ethical issues they would face, and consider the differences of working in the UK compared to where they trained or worked. All participants rated the session very good or good and said it had helped them reflect on their practice. Almost all said their practice would change as a result.

During the course of 2017 we also took 148 calls and sent 425 written responses to doctors who contacted us with questions about our guidance and how they should apply it in the situations they are facing. The service was well received, with several doctors saying it provided the answers they needed.

And in December 2017 our office in Wales, in partnership with BMA Cymru Wales and the Welsh NHS Confederation, delivered a conference encouraging doctors to participate in quality improvement activity with their local healthcare organisation. Over 90 doctors attended and were provided with examples of the impact of quality improvement and the skills needed to engage themselves. Several delegates commented that it would change their practice.

These are just examples. The case studies below show in more detail the impact our work to help doctors maintain and improve standards can have on public safety.



## Our app is helping to make standards more accessible

A growing number of doctors are making use of our MyGMP mobile application, which helps them access our ethical guidance more easily.

The tool, which is available on phone and tablet, was launched in 2016 and now has up to 2,000 visits a month. We added guidance for medical students in 2017. This way, doctors and students can access guidance during placements or on the go in a busy healthcare environment.

<sup>6</sup> See [www.gmc-uk.org/about/what-we-do-and-why/learning-and-support/workshops-for-doctors/welcome-to-uk-practice](http://www.gmc-uk.org/about/what-we-do-and-why/learning-and-support/workshops-for-doctors/welcome-to-uk-practice)

Reaction to the changes has been very positive. One student said the app had been really useful – ‘its structured layout not only makes it very convenient, it also made me more aware of the range of guidance available.’

A medical student from the University of Glasgow found the app particularly helpful for her revision. ‘Having the MyGMP app on my phone has been useful for looking at clinical guidance whilst on the bus or train to placements,’ she said. ‘All of the guidelines are stored offline in one place and it made revising for the situational judgement test and future exams just that little bit easier.’

## Providing support to international doctors

Our Regional Liaison Service (RLS), which supports doctors in England on a variety of subjects, met with 22,813 doctors in 2017 and has been closely involved in helping a group of international doctors prepare to begin work in the NHS.





Initially the RLS was approached by NHS England to provide support and information to a group of 30 European doctors who were based in Poland, where they were training before their move to Lincolnshire, where doctors are in great demand.

Using elements of our Welcome to UK practice course,<sup>7</sup> designed to introduce international doctors to some aspects of medical practice in the UK, the service held two two-hour webinars with the doctors in March and June 2017. These webinars introduced the doctors to the GMC and our guidance and gave them some context about UK medical practice.

As both the doctors and NHS England representatives were extremely pleased with how this went, we then discussed how we could support the doctors once they moved to the UK. In addition to providing GMC guidance booklets as part of an induction pack, between October 2017 and February 2018 the RLS held dedicated half-day sessions with the doctors on confidentiality, raising concerns, the duty of candour, consent, end of life care, maintaining boundaries and professional use of social media. The reaction to this was again very positive, with the medical director for NHS England (Central Midlands) calling the final session 'exceptional'.



We are now considering further sessions on applying this guidance to primary care, looking specifically at areas such as consultations, referrals and service pressures. We are also keen to maintain contact with the group to help them with any ongoing challenges they may face. In addition, we are in discussions with NHS England and Health Education England on how we can support a programme of work to recruit 2,000 general practitioners (GPs) into England over the next three years.

<sup>7</sup> See [www.gmc-uk.org/about/what-we-do-and-why/learning-and-support/workshops-for-doctors/welcome-to-uk-practice](http://www.gmc-uk.org/about/what-we-do-and-why/learning-and-support/workshops-for-doctors/welcome-to-uk-practice)



## How we helped amend Scotland's Apologies Act to support proportionate regulation

Over the last three years we have worked with the Scottish Government and other healthcare regulators in Scotland to make sure Scotland's Apologies Act does not have unintended consequences for doctors and other healthcare professionals in the country.

The aim of the Act, which came into effect in 2016, is to change the culture around apologies by making sure that they can't be used as evidence of liability within civil proceedings.

Although supportive of this principle, we were concerned the legislation might have unintended consequences, meaning that a doctor who apologised for a mistake, for instance, could not use that as evidence of insight or contrition at a fitness to practise hearing.

We worked closely with ministers, officials and the Scottish Parliament to highlight our concerns and make sure they were taken into account as part of an amendment to the legislation. As a result, the Scottish Parliament voted in June 2017 to approve an exception to the Act designed to protect the work of the GMC and other professional regulators.

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Our priority must always be to make sure doctors working in the UK have the capabilities to provide a good standard of medical practice and are supported in doing so throughout their career. Making sure our standards are understood and that legislative frameworks enable doctors to maintain them is key to this, as our case studies show.

Over the next three years we want to continue to invest in this area, in particular by:

- expanding our Welcome to UK practice sessions, aiming to cover 80% of new registrants from the current 33%
- developing plans for a new Medical Licensing Assessment exam by 2022
- increasing our investment in digital content and mobile apps to support good practice
- consistently speaking out where training or practice environments or culture jeopardise learners and doctors' ability to meet the standards we set for good medical practice
- extending the range of our services in each of the four UK countries (for example, identity checks and meetings with patients and complainants).



## Assuring the quality of medical education and training

We set the standards for medical education and training across the UK, and monitor undergraduate schools and postgraduate training environments to make sure these standards are met.



Our standards help to make sure the learning environment is safe for patients, medical students and doctors in training and of sufficient quality for learners to progress.

We regularly ask students and doctors in training about their experiences and respond to any concerns. And we constantly seek to support improvements to performance.

We have, for example, continued to explore why some groups of graduates, such as black and minority ethnic doctors both from the UK and overseas, do not progress as well through medical education as others.<sup>8</sup> We ran a pilot with several deaneries and Health Education England local offices, which gave them access to data on this for the first time and enabled them to take action, and we commissioned research that highlighted some of the barriers to change. As a result, we have already seen a number of interventions to improve the situation.

In this section we show other ways in which our work can make a difference to medical students and doctors in training, triggering change and ultimately impacting on public safety.

## National training surveys: taking action to support learners

Our annual national training surveys<sup>9</sup> of more than 75,000 doctors in training and their trainers are a vital tool in telling us just what is happening in medical education and training across the UK. That in turn enables us and providers to take action where necessary to make sure our standards are upheld.

### Case study: Altnagelvin Area Hospital A&E department, Northern Ireland

Our 2015 national training surveys highlighted serious concerns about the level of support that doctors in training were receiving from senior staff in Altnagelvin's emergency department. It also indicated that supervision was inadequate.

Although the feedback came as an unwelcome surprise, consultants took it to heart and used our findings to lobby management for more senior and middle grade staff, stressing this was essential to preserve public safety and maintain the department's training accreditation.

<sup>8</sup> See [www.gmc-uk.org/education/standards-guidance-and-curricula/projects/differential-attainment](http://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/differential-attainment)

<sup>9</sup> See [www.gmc-uk.org/education/how-we-quality-assure/national-training-surveys](http://www.gmc-uk.org/education/how-we-quality-assure/national-training-surveys)

As emergency department consultant Paul Bayliss noted: 'When junior doctors say they don't feel adequately supported they are likely telling us that our patients' safety is potentially at risk.'

As a result the department received a significant funding increase which allowed them to make radical changes to consultant rosters and provide doctors in training with more appropriate direct clinical supervision. The training programme was also refreshed. Feedback from junior doctors in the 2016 and 2017 surveys indicates the changes have led to significant improvements.

### Satisfaction rates

	2012	2013	2014	2015	2016	2017
Overall satisfaction	78.67	77.60	80.44	66.86	81.00	88.55
Clinical supervision	72.96	79.10	71.33	76.43	85.59	94.55
Clinical supervision - out of hours				67.00	83.25	92.73
Work load	28.13	40.63	30.79	23.21	32.81	43.18
Induction	85.83	90.00	82.78	84.29	93.13	90.91
Feedback	61.67	68.52	73.15	57.74	90.84	80.00

Post Specialty: **Emergency Medicine**, Altnagelvin Area Hospital A&E department

## How enhanced monitoring helps to maintain training standards

As part of our work we institute enhanced monitoring at education and training sites<sup>10</sup> where we have serious concerns about the quality or safety of medical education and training.

We work together with providers, deaneries, and health education local offices to make good the failings until there is evidence of a turnaround.

In 2017 we dealt with 94 issues that needed enhanced monitoring. In the case of 39 organisations we found evidence of improvements and were able to close our enhanced monitoring process. Here are two examples:

<sup>10</sup> See [www.gmc-uk.org/education/how-we-quality-assure/postgraduate-bodies/enhanced-monitoring](http://www.gmc-uk.org/education/how-we-quality-assure/postgraduate-bodies/enhanced-monitoring)



### Case study: Addenbrooke's Hospital, Cambridge

We began enhanced monitoring at Addenbrooke's Hospital after Health Education East of England told us it had found service priorities and the demands of administrators were being prioritised over training and educational standards in ophthalmology.

Together with Health Education East of England we set and monitored new requirements, including a named appropriate consultant for every doctor in training, a revised theatre list to make sure doctors in training get sufficient experience, monthly protected teaching and greater support for educational supervisors.

While our 2016 national training survey showed little progress, the 2017 survey revealed dramatic improvements. Our enhanced monitoring team attended a Health Education East of England visit to the provider that also found a greatly changed environment. There was now good support from ophthalmic consultants as well as guaranteed time in theatre and formalisation of out of hours support. As a result we were able to lift our enhanced monitoring measures.

### The number of enhanced monitoring cases monitored and closed in 2017

**94** cases were monitored

**39** cases were resolved

### Case study: North Middlesex University Hospital NHS Trust, London

We take any concerns about poor standards of medical education and training very seriously and act quickly to address them in partnership with others. Sometimes these concerns require serious action so that we can protect and improve the training, health and wellbeing of individual doctors.

Our national training surveys showed that doctors in training at North Middlesex University Hospital's emergency department had to deal with situations beyond their competence because of an absence of senior supervising doctors. This was closely related to recruitment problems that meant only 30% of substantive medical posts in the department had been filled.

In the spring of 2016 we made a visit together with Health Education England (HEE), which showed a culture of bullying as well as inadequate supervision and deficiencies in doctors' competence and capabilities.

Working closely with our partners we laid down a number of conditions that, if not met, would mean that the doctors in training were removed from the department. As a result, the trust agreed to move in resources from neighbouring trusts to support the department as well as making changes in the senior and clinical leadership. A series of follow-up visits showed that doctors in training were now receiving better support and these improvements were confirmed in our 2017 national training survey.

Given the trust's continuing recruitment problems, there is a risk that, once neighbouring trusts withdraw their loaned resources, the situation will worsen. We will continue to work with all organisations involved to keep the situation under review to make sure that doctors in training are being properly supported.

In some enhanced monitoring cases we have also had to go further and make sure that doctors in training were removed from specific departments. It was the case at East Kent Hospitals University NHS Foundation Trust, for example, where we were concerned that there was a poor level of clinical supervision that was creating an unsafe and unsupportive environment for doctors in training and, if left unchecked, it could impact on public safety. In partnership with Health Education England we arranged for doctors in training to be removed from some medicine specialties on the Kent and Canterbury site and relocated to other sites across the trust.

The real challenge in situations like those at North Middlesex and East Kent is to achieve sustainable improvement. We now have a seat on the NHS Joint Oversight Group which gives us greater influence in determining how we can monitor and support high risk organisations.

## Using student engagement to highlight probity issues

We made significant improvements to our student engagement programme in Scotland in 2017, working more closely with school professionalism leads and other educators and tailoring our events to the local curriculum as well as topical issues.

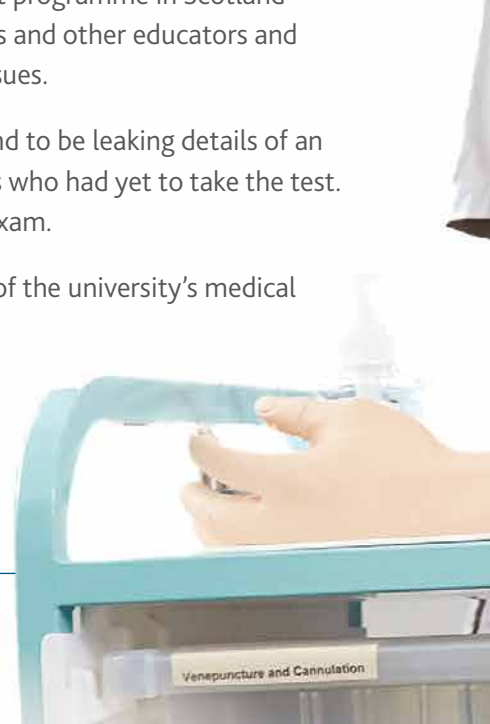
“ The session put my mind at ease that the GMC exists to support us all.

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Medical student.

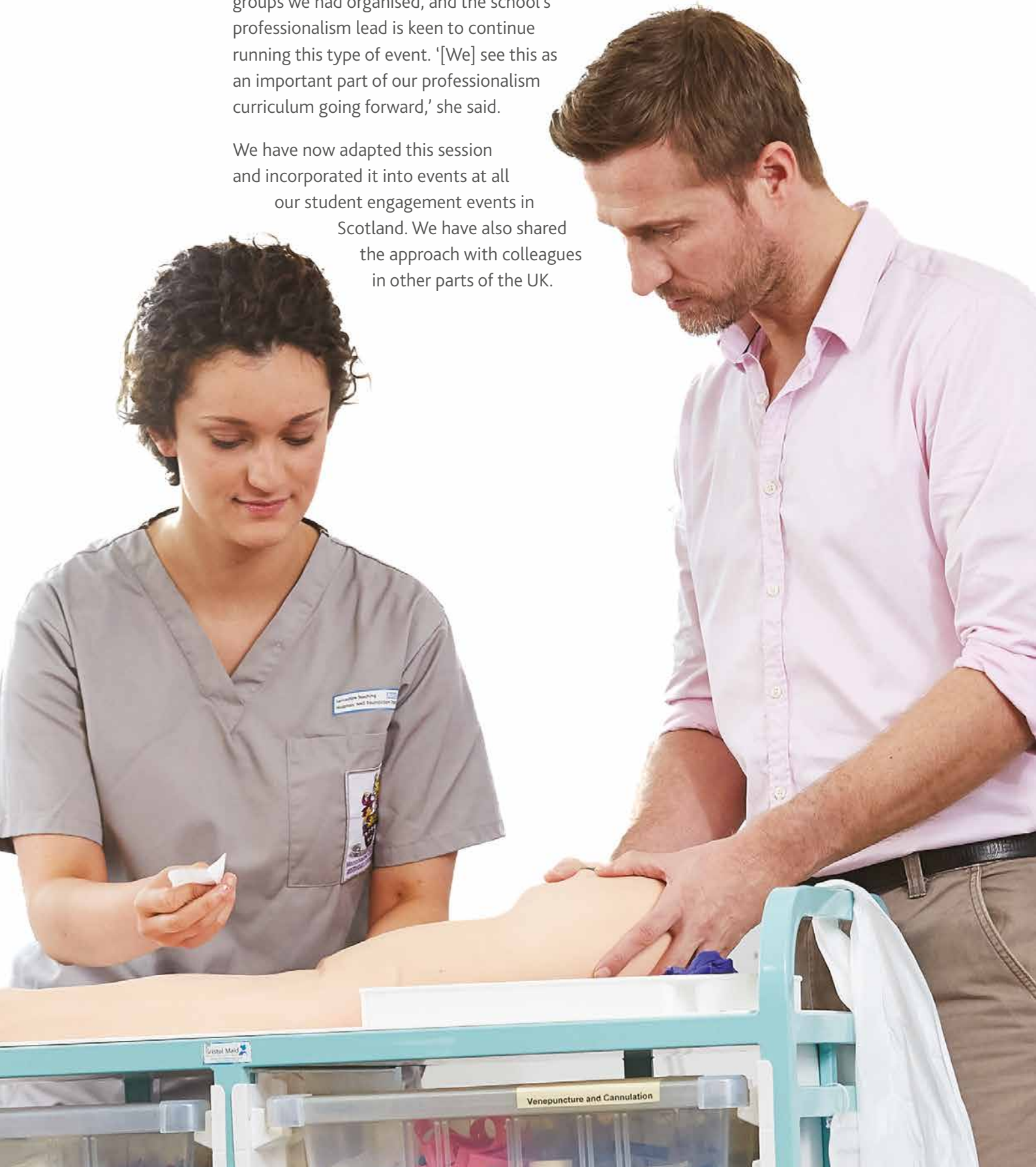
For example, some medical students were found to be leaking details of an assessment through social media to colleagues who had yet to take the test. As a result the entire cohort had to re-sit the exam.

We responded by collaborating with the head of the university's medical school and the professionalism lead to deliver an interactive session for third year students highlighting relevant guidance on honesty, probity and raising concerns about exams. The session included group work using scenarios from our existing resources as well



as specially devised scenarios about the exams. Students and educators were both very positive about the session. We received feedback from 15 of the student discussion groups we had organised, and the school's professionalism lead is keen to continue running this type of event. '[We] see this as an important part of our professionalism curriculum going forward,' she said.

We have now adapted this session and incorporated it into events at all our student engagement events in Scotland. We have also shared the approach with colleagues in other parts of the UK.



## New standards to make postgraduate training more flexible for doctors

In 2016 contract negotiations between the Department of Health (England) and the BMA's Junior Doctor Committee and consultation with stakeholders identified that doctors in training were concerned about the lack of flexibility in training. In particular, the structure and processes in training created barriers for doctors in training who seek to change specialty.

So we began a review of flexibility in postgraduate training,<sup>11</sup> and in March 2017 we shared our action plan for improving it with the health ministers of the four UK countries, identifying key actions we will take with others to increase flexibility and options in this field.

“ Inclusion of generic professional capabilities in all curricula will ensure that professionalism receives the priority and emphasis it requires during training.

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Bill Allum, Chair of the Joint Committee on Surgical Training, and the Academy of Medical Royal Colleges' lead for production of generic professional capabilities implementation guidance for colleges.

We then introduced medical education reforms to support this work, again aiming to make postgraduate training more flexible for doctors. We set out that by 2020 medical colleges and faculties will update all 103 existing postgraduate medical curricula against our new *Excellence by design* standards.<sup>12</sup> All the curricula will have to demonstrate how the proposed training will promote the vision of a more generalist and more broadly skilled workforce.

Integral to these new standards is our new Generic professional capabilities framework.<sup>13</sup> The framework covers capabilities in broader areas of professional practice, such as communication and team working, necessary for all doctors to provide high quality care, and which given their generic nature, should be transferable across most specialties.

Welcoming the new generic professional capabilities framework, Bill Allum, Chair of the Joint Committee on Surgical Training, and the Academy of Medical Royal Colleges' lead for production of generic professional capabilities implementation guidance for colleges, said: 'Inclusion of generic professional capabilities in all curricula will ensure that professionalism receives the priority and emphasis it requires during training, in order to ensure doctors develop the key professional values and behaviours, knowledge and skills required'.

11 See [www.gmc-uk.org/education/standards-guidance-and-curricula/projects/promoting-flexibility-in-postgraduate-training](http://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/promoting-flexibility-in-postgraduate-training)

12 See [www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/excellence-by-design](http://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/excellence-by-design)

13 See [www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework](http://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework)



In November 2017 we also published an updated position statement on less than full time training<sup>14</sup> (LTFT), confirming that training providers must agree to LTFT arrangements, and setting out conditions to make sure the duration and level of quality of LTFT training is not less than that of continuous training.

We will continue this work to better support doctors and achieve our vision to give them clarity and confidence on what switching specialties will mean for them. We recognise that to do that in full we need the UK government to make the law less restrictive, so that we can be more agile in approving training.

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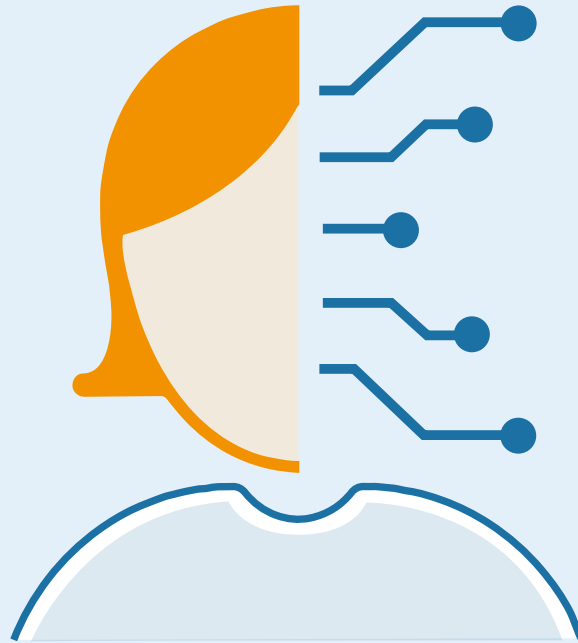
As health service difficulties grow so the pressures on medical students and doctors in training increase. We must therefore redouble our efforts to make sure their training environment is a healthy and secure one.

We want to instil increased confidence in the ability of training environments to support doctors who are learning. We also want to be trusted to speak out on learners' behalf where training or practice environments or culture jeopardise their ability to meet the standards we set for good medical practice.

Over the next three years we will:

- develop a medical student engagement plan aimed at preparing students to become part of the registered profession
- target our regulatory action more effectively where training systems for doctors are under pressure
- develop a protocol or toolkit for how organisations will work together when serious concerns are raised about training environments. We will explore a framework for joint quality assurance by professional regulators and system regulators.

<sup>14</sup> See [www.gmc-uk.org/news/media-centre/media-centre-archive/gmc-statement-on-less-than-full-time-ltft-training](http://www.gmc-uk.org/news/media-centre/media-centre-archive/gmc-statement-on-less-than-full-time-ltft-training)



## Sharing intelligence and collaborating with partners

The UK's health services are currently facing major challenges with significant implications for doctors and patients. We recognise some of these issues can only be tackled effectively by working closely with other regulators and healthcare organisations, and by speaking out when systemic issues put patient safety at risk.

We currently collaborate on a range of themes including legislation, harm reduction and data sharing to help inform wider workforce strategies. We also work with our partners to support and promote patient safety and good medical practice. And we make our voice heard when our data reveals significant problems existing or likely to emerge in the UK's healthcare systems.

We also seek to streamline our communications with stakeholders to avoid unnecessary duplication. For instance, in 2017 our Northern Ireland office held a single event to update stakeholders on a number of medical education developments. It meant that instead of having to go to a range of events, participants attended just one and were able to speak to us about many different issues on the same day.

The case studies in this section show how we have worked with our partners to promote safe practice, highlight key issues affecting the UK's healthcare systems, and aid coordinated workforce planning. In the process we believe we are helping to highlight emerging concerns – in medicine and the wider healthcare system.

## How data sharing can support collaboration

We hold a wealth of data about doctors and the organisations where they work. We are committed to sharing this information and our insights on this data with others to improve patient care and influence workforce planning.



In 2017 we launched two major data products that aim to improve collaboration with our users and regulatory partners.

GMC Data Explorer,<sup>15</sup> available on our website, allows users to find answers to their questions quickly and reliably without having to complete a request form or wait for a response.

The new tool, which is updated daily, offers instant information on the make-up of the medical register, revalidation, doctors' training and fitness to practise.

<sup>15</sup> See [www.gmc-uk.org/about/what-we-do-and-why/data-and-research/gmc-data-explorer](http://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/gmc-data-explorer)



We have also created data dashboards – offering information on a more restricted and confidential basis – for responsible officers and regulators.

The designated body dashboard for responsible officers provides secure data on revalidation, fitness to practise and the national training survey within their own organisation. The dashboard for regulators and healthcare improvement organisations provides similar information for regulatory bodies within their area of responsibility.

Our office in Wales has also set up an information sharing agreement with Healthcare Inspectorate Wales (HIW) enabling us to share information from our register relating to education, revalidation and fitness to practise. This helps to inform an overall view about the healthcare systems in Wales. We also anonymously share qualitative feedback from doctors and doctors in training that we meet as part of our engagement programme across Wales, which enables HIW to triangulate their own inspection data from a number of different perspectives.

## UKMED – the database that is boosting workforce planning

We have been helping to run a ground-breaking data programme allowing researchers to track cohorts of doctors from entry into medical school to postgraduate training and practice. In the process we and our partners are learning more than ever before about doctors' career choices and progression.

The programme – the UK Medical Education Database (UKMED)<sup>16</sup> – has the potential to improve standards, aid workforce planning and support the regulation of medical education.

UKMED pulls together a range of information on the performance of UK medical students and doctors in training across their education and future career. It is the first time that undergraduate and postgraduate data has been brought together in this way.

By linking information, such as assessment results, UKMED aims to highlight doctors' pathways through their school, university and subsequent career. It also offers workforce planners much richer data on doctors' movements and patterns of work than ever before.

The UKMED data has, for instance, enabled NHS Education for Scotland (NES) to understand better the crucial link between the home country of the entrant and their retention in the NHS Scotland workforce. 'This would not have been possible without UKMED,' said Dr Colin Tilley from NES.

<sup>16</sup> See [www.ukmed.ac.uk](http://www.ukmed.ac.uk)

In future, UKMED could also enable us to analyse schools' and colleges' selection techniques and the effectiveness of different educational interventions.

We worked with partners in graduate and postgraduate education and beyond to create the UKMED database. The information produced is accessed through a secure research environment.

## ***The state of medical education and practice in the UK report – pointing the way forward***

Our 2017 report into the state of medical education and practice<sup>17</sup> in the UK has highlighted a number of challenges facing the medical workforce against a backdrop of ever-rising demand for health care.



The report, which draws on information on our register about doctors and medical students working and training in the UK, and complaints about doctors, says the medical workforce has reached a 'crunch' point. It identifies a number of trends that could make the situation worse if they are not addressed as a matter of urgency.

These include:

- the supply of new doctors into the UK has not kept pace with changes in demand
- dependence on non-UK qualified doctors has grown in some specialties
- the UK is at risk of becoming less attractive to overseas doctors to work, with 6,000 fewer non-UK doctors on the register compared with six years ago
- the pressure on doctors in training is continuing, with 41% reporting workloads that were heavy or very heavy and 22% reporting a lack of sleep.

The report calls for a concerted effort to maintain the supply of good doctors. To do this the workforce must evolve to meet the changing needs of patients, workplace culture has to improve and employers must reduce the burden on doctors wherever possible.

17 See [www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk](http://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk)



“ We welcome the regulator’s recognition that the NHS is in the midst of a workforce crisis and that decisions made today will have a significant impact on what the health service and patient care will look like in 20 years’ time.

”

Dr Chaand Nagpaul,  
BMA Council Chair.

We are taking steps to meet this challenge, including supporting NHS England’s drive to recruit more GPs from abroad, allowing easier movement between postgraduate specialties and streamlining our fitness to practise investigations.

But making sure we have the right number of doctors with the right skills in the right places for patients can only be achieved in conjunction with partner organisations and the our health services as a whole.

The information and recommendations in our report should feed into these wider workforce strategies. For example, the NHS’ employer and provider bodies in England have both welcomed the report which would, they said, help to inform the Health Education England’s workforce strategy.

#### Where our doctors come from - source of licensed doctors on the register, from 2012 to 2017

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

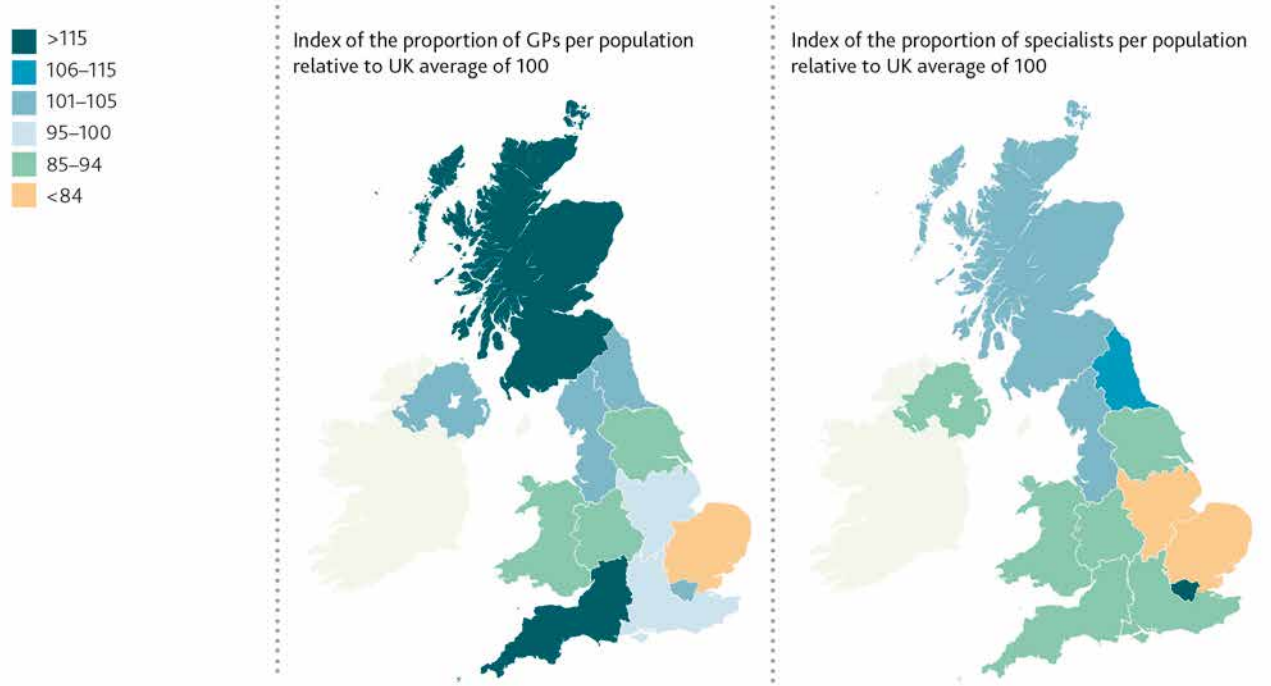
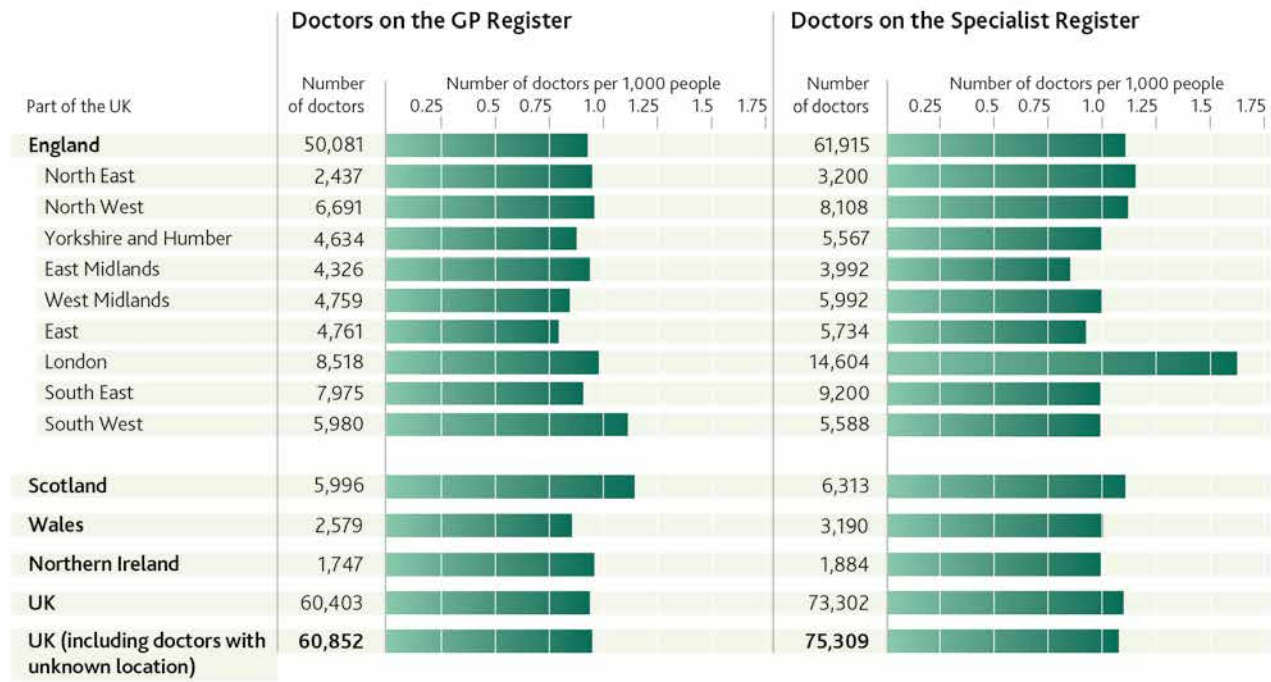
## Place of primary medical qualification and ethnicity of licensed doctors in the ten largest specialty groups in 2017 and change, from 2012 to 2017

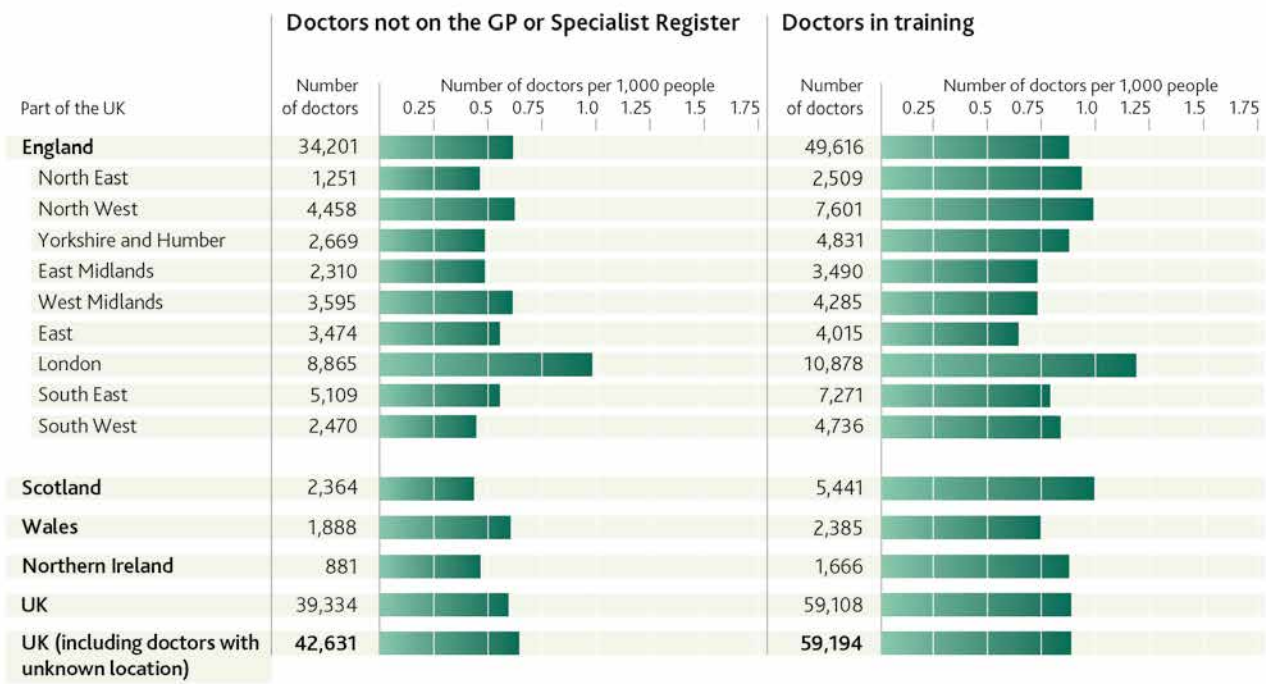
MEDICINE	PLACE OF PRIMARY MEDICAL QUALIFICATION					Total % BME	CHANGE DURING 2012-17		
	UK	EEA	IMGs	Non-UK graduate			Overall	Non-UK graduates	BME
All	12,762	2,531	4,074	6,605			▲ 16%	▲ 23%	▲ 38%
% BME	20%	7%	88%	57%	33%				
<b>SURGERY</b>									
All	8,092	2,602	2,788	5,390			▲ 8%	▲ 4%	▲ 27%
% BME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

The percentage of BME doctors is calculated as a percentage of only doctors who disclosed their ethnicity.

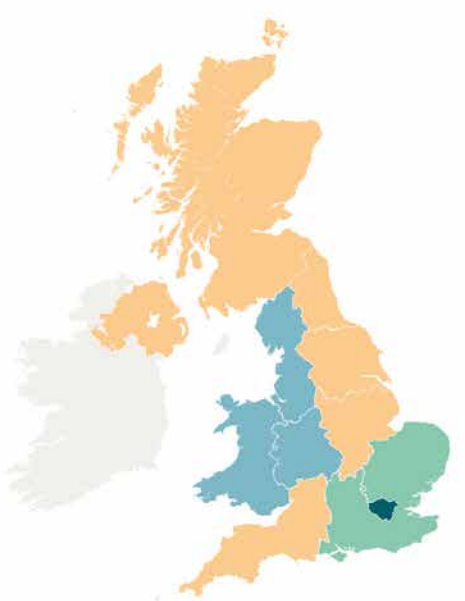
Doctors whose ethnicity is 'not recorded' as not included in these percentages, but are included in the total figures.

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

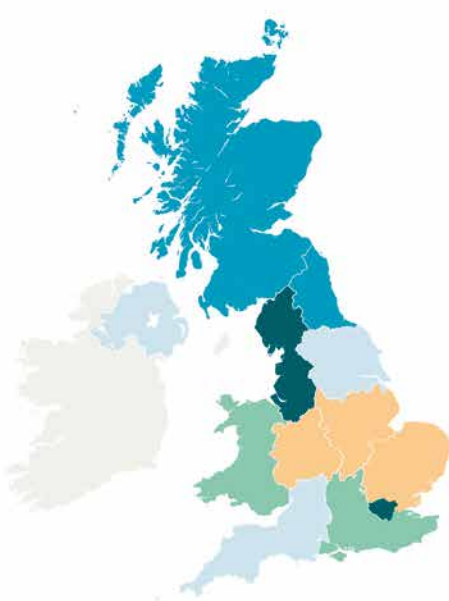




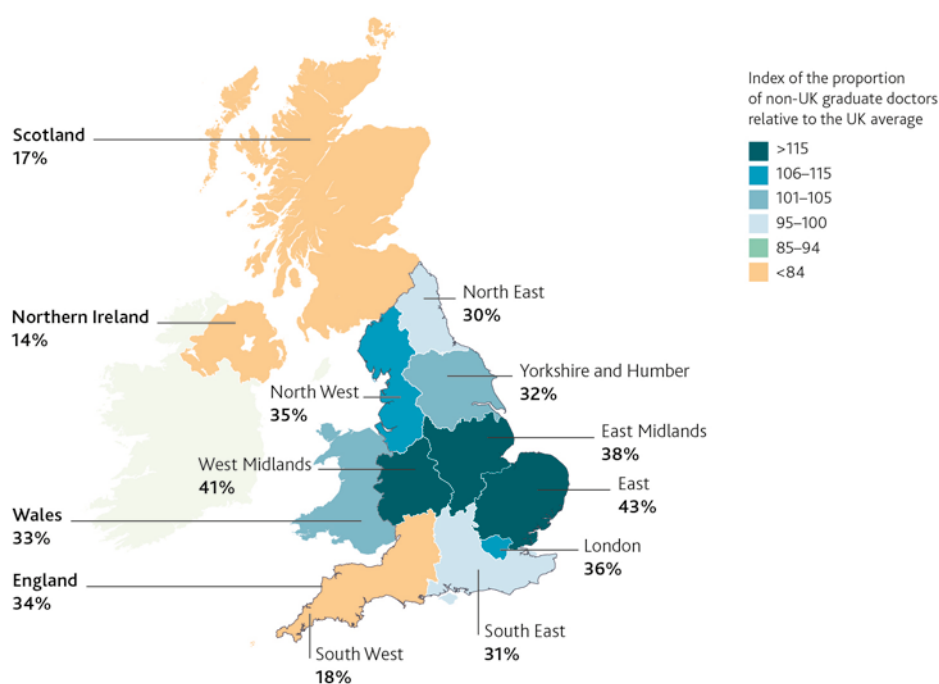
Index of the proportion of doctors on neither register per population relative to UK average of 100



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



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



We plan to use our data, intelligence and horizon scanning capabilities to greater effect so we can better understand emerging risks and act to support doctors in maintaining high standards of practice. As our case studies demonstrate, close collaboration with our partners will be crucial if we are to share this intelligence where it is needed most – and so respond to workforce and healthcare pressures.

Over the next three years we will:

- implement our transformation programme which will provide us with greater capability and agility to identify and act upon emerging issues
- share more of our data and intelligence with others – and they with us – to contribute to a fuller understanding of, and response to, risk and trends across the health systems
- encourage better coordination of activity among regulators to develop targeted addressing of concerns such as bullying at work or health and wellbeing issues
- complete the implementation of our digital transformation to deliver content and products, including improvements to our website, that meet the needs of those we work with and for.





## **Delivering responsive and proportionate regulation**

Against the backdrop of a health care system that is under increasing pressure, we want to make sure doctors are supported by regulation that eases rather than adds to the pressures of the system they work within.

We need to be proportionate in the actions we take to protect the public and safeguard medical education and practice. In recent years we have been looking at how we can make our regulatory process as responsive as possible while ensuring patient safety is never jeopardised.

Based on feedback we received from doctors, we have taken steps to make the revalidation process less demanding for doctors. Our relaunched guidance<sup>18</sup> on the subject clarifies what information doctors need to provide for their annual appraisals. This helps to make sure doctors don't feel pressurised to gather evidence that is unnecessary or excessive.

Regulation of medical associate professions would help associates reach their full potential as a professional group while ensuring patient safety. And we believe we are well placed to provide that regulation.

We have also made it easier for doctors to remove their names voluntarily from the register by introducing a more flexible application process – and initial evidence suggests this has been welcomed, with an increase in applications compared to the past.

And as the case studies below show, we have extended our provisional enquiry process to make sure we only conduct investigations into doctors' fitness to practise where it is essential that we do so to address significant public safety issues; and we have invested in ways in which we can support doctors undergoing investigations.

We are also constantly looking to reduce the financial impact of regulation on doctors as much as possible. We reduced our annual retention fee for all doctors from April 2018, and introduced significant discounts on registration fees for newly qualified doctors.

And we are ready to take on new challenges. For example, we responded positively to the consultation carried out by the Department of Health and Social Care (England) regarding the regulation of medical associate professions: as medical associates work closely with doctors, we believe there is a strong argument that we should accept responsibility for them, and provided that adequate funding and legislative changes are put in place, we would be in a good place to regulate also these roles.



<sup>18</sup> See [www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation/about-this-guidance](http://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation/about-this-guidance)

## How provisional enquiries are reducing regulatory pressure

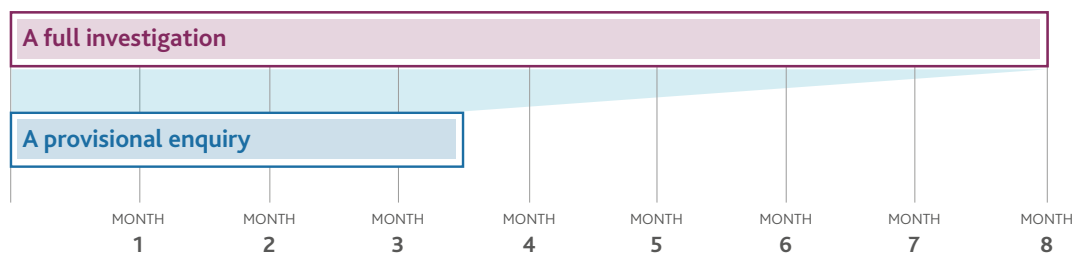
We take concerns raised about doctors' behaviour, health or performance very seriously, and, where necessary, we will take action to prevent a doctor from putting the safety of patients or the public's confidence at risk.

At the same time, there is every reason to avoid the costs and stress of a full investigation if risks to public safety are limited or can be addressed in other ways. And the evidence shows this is often the case. At present, around 75% of cases that we are required to investigate due to the current legislative framework do not result in substantive action.

In the last few years we have been working to address this by introducing a system of provisional enquiries – that is, making a few initial enquiries that allow us to assess whether or not we need to open a full investigation.



In 2017 we completed over 500 provisional enquiries and were able to close two thirds of the cases without a full investigation, saving time and stress for the doctors involved and allowing us to focus our resources on the more serious cases.



In addition we ran a pilot focusing on incidents where a doctor has made a one-off clinical mistake. Again, two thirds of the cases were closed with no further action. We also hope to extend provisional enquiries to some cases where the concerns relate to a doctor's health.

On average provisional enquiries take between three to four months to complete compared to eight months for a full investigation.

We have also updated our thresholds guidance<sup>19</sup> to make it clearer when we can and cannot take action. Responsible officers have told us this has helped them support some doctors – particularly those with health concerns – at a local level rather than referring them to us.

The guidance 'will empower responsible officers to act,' said one responsible officer. 'I feel [it] supports my management of concerns locally, where appropriate, for the benefit of the doctor, their service and patients in a timely and constructive manner.'

## Doctor Contact Service is helping to reduce stress of hearings

Fitness to practise hearings can be confusing and stressful experiences for doctors, particularly those who are representing themselves without the support of a barrister. This is why the Medical Practitioner Tribunal Service (MPTS) recently set up its Doctor Contact Service.<sup>20</sup>

The service is provided by staff from across the MPTS who seek to support doctors and make their experience of the hearing process a little less daunting. Staff can point doctors to

<sup>19</sup> See [www.gmc-uk.org/-/media/documents/dc9089-referral-guidance\\_pdf-66767403.pdf](http://www.gmc-uk.org/-/media/documents/dc9089-referral-guidance_pdf-66767403.pdf)

<sup>20</sup> See [www.mpts-uk.org/hearing/11905.asp](http://www.mpts-uk.org/hearing/11905.asp)



**76** doctors seen  
**29** gave feedback  
**98%** positive

“ I’m unrepresented so it was lovely to have someone to talk to and clarify the procedures.



Doctor taking part in a hearing.

useful support materials and provide information about the process, which can help reduce doctors’ stress, anxiety and sense of isolation when attending a hearing.

In its first year the Doctor Contact Service saw 76 doctors. Of these, 29 gave feedback and the satisfaction rating of 4.9 out of 5 indicates it is having a positive impact.

In one case a doctor who had arrived alone for a hearing was clearly in a distressed state. A staff member sat down with them and assured them there was plenty of time to compose themselves before the hearing began. They also had the chance to ask questions about the process and discuss their immediate concerns. As a result the doctor was able to refocus and begin preparing for the hearing.

Afterwards the doctor said how grateful they were for this support. ‘I’m unrepresented so it was lovely to have someone to talk to and clarify the procedures. It was good to be able to raise one or two points in my case. An invaluable service.’

## Supporting doctors experiencing health-related issues

Over the course of last year we have invested in ways to support doctors who are unwell or vulnerable, before and during investigation processes.

For example, in March 2017 we set up a dedicated communication investigation team, tasked with overseeing communications to doctors undergoing investigation who are experiencing health-related issues. The team ensures that in our letters to these doctors we only include what the doctor needs to know at that particular point in the process and what they need to do next. This avoids the doctor having to process additional information at a stage where it is not yet relevant. These letters also give earlier advice about the Doctor Support Service,<sup>21</sup> provided by the BMA on our behalf and available to help all doctors through the investigation process.

Dr Anna-Maria Rollin at the Royal College of Anaesthetists told us that these changes represent a huge improvement in our communication, and that our ‘increased emphasis on support for the doctor, through the medical defence organisations and the Doctor Support Service, is welcome.’

Our Employer Liaison Service<sup>22</sup> can also help to facilitate local conversations to support doctors with health concerns. This prevents concerns from being escalated to the GMC

<sup>21</sup> See [www.gmc-uk.org/concerns/information-for-doctors-under-investigation/support-for-doctors/doctor-support-service](http://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/support-for-doctors/doctor-support-service)

<sup>22</sup> See [www.gmc-uk.org/about/how-we-work/liaison-and-outreach/employer-liaison-service](http://www.gmc-uk.org/about/how-we-work/liaison-and-outreach/employer-liaison-service)



when they could be addressed in other ways, and is particularly helpful where a number of organisations are involved.

For example, one of our employer liaison advisors (ELAs) helped in a case where there were long-running health concerns about a doctor in training. Whilst these concerns did not cross the GMC threshold for action, it was recognised that the doctor needed support in several ways including occupational health. Our ELA was concerned that there was a lack of dialogue between Health Education England and the employing provider about arranging support for the doctor. The ELA arranged a three way conversation for the provider and Health Education England to discuss what support had been in place for the doctor at other training locations to give all parties assurance that the doctor would be able to practise safely and there was no risk to patients or the doctor concerned.

This helped provide a joined up and proportionate response to the issue, focusing on making sure that the doctor received the support they needed rather than referring them to our fitness to practice procedures.

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Our aim is to make sure that regulation happens in the right way, in the right place and at the right time. That means we will continue to look for ways of streamlining the present regulatory system, for the benefit of both doctors and the public. In doing this we believe we will create a model of regulation that can anticipate and be responsive to changing healthcare systems and workforce strategies.

Over the next three years we will:

- explore and pilot a 'local first' approach when dealing with concerns about doctors. The aim will be to manage more cases at a local level rather than referring on to a more formal hearing. This will reduce unnecessary referrals and achieve more timely resolutions
- explore the development of an educational support programme for doctors who have been subject to low level complaints that have not yet reached the threshold for action against their registration to reduce the risk of more serious problems and regulatory action later on
- keep our fees structure under review, making sure our fees remain robust, equitable and transparent
- work with other regulators and health organisations to make our processes more user friendly for doctors, student, educators and healthcare providers
- continue to campaign for legislative reforms that will enable us to streamline our processes and help us deliver ever more responsive and proportionate regulation.

## CONCLUSION

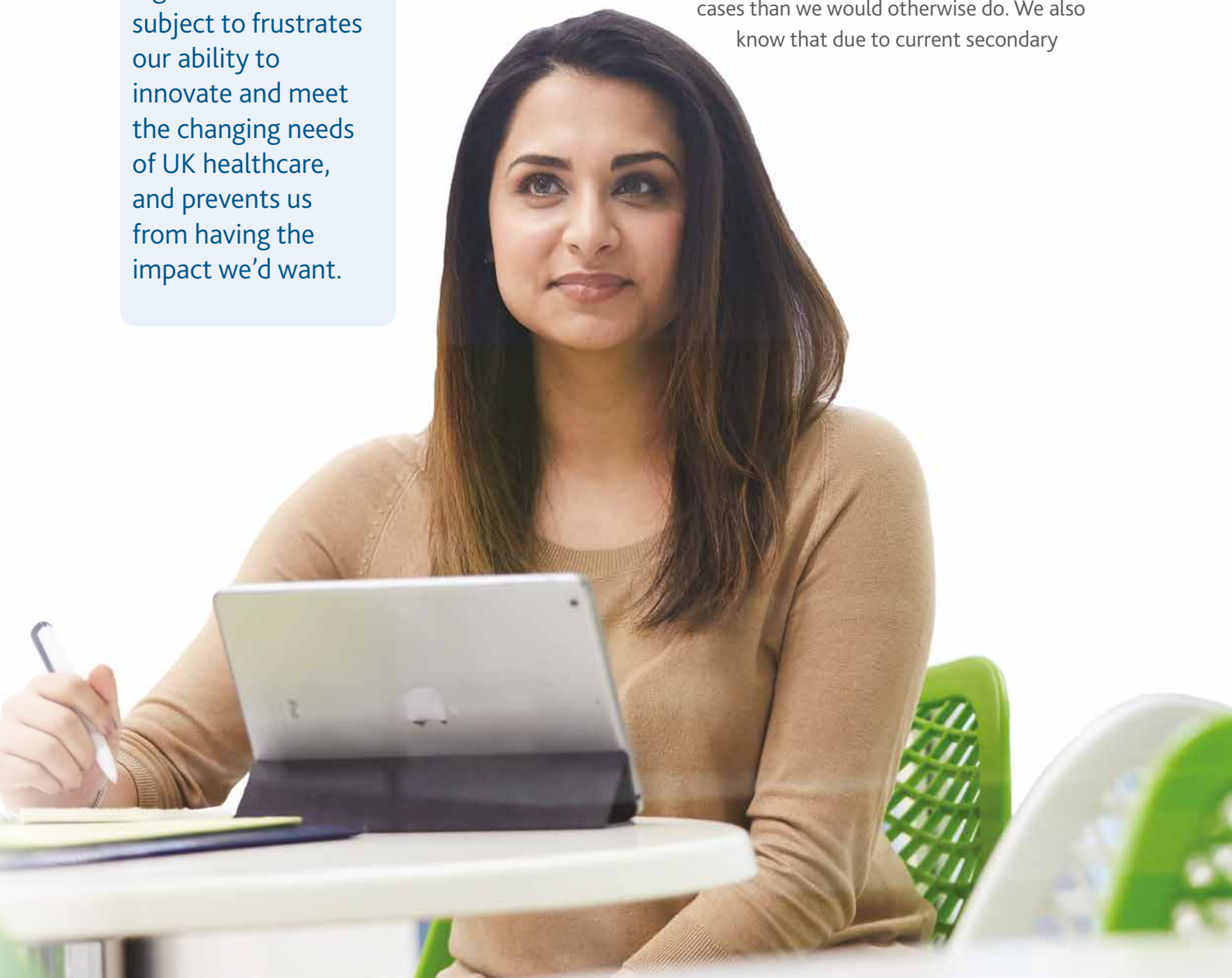
The case studies presented in this report are just a few examples of how our work can impact positively in many different ways on public safety and the quality of care.

In particular we have seen how working with doctors to maintain and improve standards, and assuring the quality of education and training, are key elements of our regulatory role and can have a big impact on both doctors' and patients' wellbeing.

The outdated and prescriptive legislation we are subject to frustrates our ability to innovate and meet the changing needs of UK healthcare, and prevents us from having the impact we'd want.

We could do much more in this respect if the laws governing our work were changed. The outdated and prescriptive legislation we are subject to frustrates our ability to innovate and meet the changing needs of UK healthcare, and prevents us from having the impact we'd want.

So for example we have to investigate many more cases than we would otherwise do. We also know that due to current secondary



legislation, doctors who have not gone through a conventional training programme but wish to demonstrate they have the equivalent knowledge to apply to our specialist or GP register are forced to partake in a slow and burdensome application process.

At the same time it is also clear that with health services under enormous pressure, the need for vigilance to maintain standards is more important than ever. The case studies in this report show how, by working together with our partners, we have been able to make a real difference, and we will continue to collaborate with them.

More recently we have also been considering the impact our decision to appeal the MPTS's ruling on the GMC v Bawa-Garba case has had on the medical profession, and have begun work to address the issues this case has brought to light. We will account for this work in next year's edition of this report.

Much of this work is already in line with our corporate strategy for 2018–20<sup>23</sup>, which includes plans to deliver ever more responsive and proportionate regulation, change our culture to achieve a clearer sense of purpose, and measure the impact of our work more rigorously.

In doing all of this we will continue to focus on our role in protecting the public – working with doctors, for patients, in everything we do.

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For more information on our activities see our Annual report 2017 as well as past impact reports at [www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/our-impact](http://www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/our-impact), or feel free to contact us on 0161 923 6602 or [gmc@gmc-uk.org](mailto:gmc@gmc-uk.org).



<sup>23</sup> See [www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/corporate-strategy](http://www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/corporate-strategy)



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