To consider

Basic Medical Education Delivered Overseas

Issue

1. How to modify our regulatory statutory framework to recognise graduates who have followed a course delivered by a UK university but at an overseas campus.

Recommendation

2. To agree that we should ask the Department of Health (England) to amend the Medical Act 1983 to enable the GMC to recognise undergraduate medical programmes delivered by UK universities overseas (paragraphs 10-18).

Further information

3. If you require further information about this paper, please contact us by email: gmc@gmc-uk.org or tel. 0161 923 6602
Background

4. Under Strategic Aim One of the Business Plan 2011, we have undertaken to continue ‘to register only those doctors that are properly qualified and fit to practise’. Under Strategic Aim Three we commit to ‘provide an integrated approach to the regulation of medical education and training’ which includes the quality assurance of basic medical education delivered by UK medical schools.

5. As previously reported to Council, there are a number of overseas initiatives involving UK medical schools which are at various stages of development. The most advanced is Newcastle/Malaysia, which received its first students in September 2011 (those students spent their first two years in Newcastle and thus, subject to our quality assurance activity, will graduate in 2014). Subsequent cohorts will undertake their entire study in Malaysia. St George’s University of Nicosia admitted its first students in 2011, and (subject to our quality assurance) will graduate their first cohort in 2015. (The St George’s programme is for graduates and is therefore four years rather than five.)

6. These developments present challenges to the current regulatory framework:

   a. It was never Parliament’s intention that the GMC should divert its energies and resources to quality assuring the training of doctors in other countries.

   b. We are concerned about the practicality of quality assuring courses provided wholly in other cultures and different healthcare contexts.

   c. The process involves giving an assurance that a course is not just equivalent to a UK delivered course but that it likewise meets all the standards and outcomes in *Tomorrow’s Doctors*. Consequently, as things stand the GMC’s statutory framework would result in an entitlement (subject to fitness to practise not being impaired) to provisional GMC registration for students who have trained entirely abroad and may have had limited interaction with patients in English (other than in a clinical assessment).

   d. If such students are granted a UK primary medical qualification, they are eligible for UK provisional registration. In turn, that gives a platform for clinical exposure to UK patients (albeit under supervision). But it is unclear what proportion of such students would wish to continue their training in the UK during their subsequent career.

   e. Overseas initiatives have little to do with current or future UK patients or the UK health system.

   f. Our key standards and outcomes document *Tomorrow’s Doctors* is drafted very much in, and for, the UK healthcare context. It was never designed to be applied in non-UK healthcare settings, and in some respects is difficult to apply in overseas settings. Its primary purpose is to ensure that medical graduates are properly prepared for UK clinical practice and to enter the UK Foundation Programme.
g. The legal, ethical, social, cultural and religious framework in other countries may not sit comfortably with UK structures and norms. So there may be reputational risks for the GMC in operating in other (unfamiliar) jurisdictions.

h. The current model depends on institutional recognition. This means that we do not have properly targeted powers. If the overseas campus does not meet our standards, the only formal power we have is to withdraw recognition of a UK university completely. It seems disproportionate to do this if our concerns are limited to the overseas campus. Such an ‘all or nothing’ power is a very blunt instrument.

i. We have no legal powers to recover our actual or opportunity costs, although we are reimbursed for our direct costs (mainly overseas travel and accommodation) under agreements made with the medical schools concerned.

7. But undertaking overseas quality assurance activity does potentially have real benefits:

a. UK medical education is highly regarded internationally. There are economic and reputational benefits for the UK in making the most of its standing in that respect.

b. There are also advantages for the countries in which UK higher education institutions establish campuses. These include fostering higher standards of medical practice to benefit patients there, and encouraging aspirant doctors to train – and then practise – in their own country rather than emigrating.

c. UK medical schools can benefit from cross-fertilisation of ideas from their overseas campuses. Moreover, students here have potentially much to learn from understanding, or better still practising, medicine as it is delivered in an environment completely different from the UK’s.

8. Members agreed in July 2011 that we should explore whether it would be possible to amend the Medical Act 1983 such that overseas programmes, although quality assured by the GMC, would not entitle a graduate to provisional registration with us. The GMC would still carry out quality assurance overseas, but the consequences of approval would alter. This might meet the wish of medical schools to have a GMC quality ‘kite mark’ for an overseas campus, while enabling some flexibility in the implementation of aspects of *Tomorrow’s Doctors* to accommodate non-UK health systems but without any lowering of standards.

9. This paper updates Council on the development of our thinking since the discussion last year and invites Council to agree that we should continue discussions with the Department of Health (England) to amend the Medical Act in accordance with the model set out in the remainder of the paper.
Discussion

10. It remains clear that the Government will not relieve us of the responsibility, imposed in primary legislation, of quality assuring medical education overseas. However, officials previously indicated support for more limited changes to the legislative framework; including powers to recover the costs of overseas activity and to differentiate between programmes delivered in the UK and programmes delivered overseas. More recently, discussions with the Department of Health have indicated support for the kind of approach foreshadowed in Council’s discussion of July 2011, provided that the UK’s wider interests are protected.

11. The issues that we believe need to be addressed in a revised legislative framework are:

a. The introduction of the legal power to maintain lists of approved programmes rather than only institutions (which the Law Commissions have proposed in their recent consultation on reforming the legislative framework for professional regulators). A similar approach has also been proposed for the main directory of medical schools (the Avicenna Directory) which will in future list approved medical education programmes rather than schools. But this legal power would be particularly relevant in the context of overseas quality assurance as it would allow us to make a distinction between UK and overseas programmes delivered by a medical school.

b. Absolute clarity on the routes to provisional and full registration for graduates of overseas programmes.

c. An approach that can cater for both EEA and non-EEA programmes.

d. Enabling overseas programmes which have been quality assured by us to gain the public recognition that flows from such approval. In short, to retain the benefits of the GMC’s ‘kite-mark’ role.

e. Legal powers to recover our full economic costs.

12. We believe that doing nothing is not an option: the current legislative model is not fit for purpose in the longer term for the reasons set out at paragraph six.

13. Instead, we should develop a new framework under which we would treat graduates from GMC-approved overseas programmes as holding an acceptable overseas qualification rather than a primary UK qualification. There would be one or more new approved lists contemplated by the Act, to identify those programmes that we have quality assured (such as the ‘GMC Overseas Programmes List’ and ‘the GMC European Programmes List’). We have sought advice from leading counsel on this proposal and have received reassurance that it is both reasonable and pragmatic.
14. Under this model, a medical education programme would not be a basis for a primary UK medical qualification unless the programme was mainly delivered in the UK. Any programme delivered mainly outside the UK but quality assured by the GMC would be eligible for inclusion on the new Overseas or European list only.

15. The reason for saying that a programme should be delivered ‘mainly’, rather than entirely, in the UK, is that we should avoid unwittingly making it more difficult for students to spend some time abroad, whether at their school’s overseas campus, on an elective in another country or under an exchange programme. On the contrary, the regulatory framework should actively be seeking to encourage students (and trainee doctors) to spend time some overseas as the experience they can gain is relevant not only to the development of their clinical skills and understanding of global health issues, but as importantly it can promote attributes such as adaptability, managing uncertainty, resilience and self-awareness which are crucial elements of medical leadership. The need for greater flexibility in training programmes is one of the themes within the Shape of Training review led by Professor David Greenaway.

16. The route to registration for graduates of these programmes would depend (as now) on a combination of nationality and whether the qualification is regarded ‘overseas’ or European.

17. From the point of view of the medical school, although graduates would be regarded as holding an acceptable overseas qualification, the inclusion of its overseas programme on a list of approved GMC Overseas Programmes (or GMC European Programmes) would distinguish the programme from other acceptable overseas qualifications that were not GMC ‘kite-marked’ in this way. Discussions with DH(E), with medical schools and with other key interests have underlined that the key benefit flowing from quality assurance is the GMC’s recognition of the programme, as distinct from a graduate’s eligibility to apply for GMC registration.

18. The benefits of adopting this approach (along with power to recover our full economic costs) as part of a revised legislative framework would include:

   a. **Greater clarity and transparency.** A UK primary medical qualification would mean what its name and common sense suggest it should mean: that the holder has completed their studies in the UK. For those who have not, their status would be more accurately reflected by inclusion on an appropriately named list – GMC Overseas Programme, or GMC European Programme, as the case may be. This would reduce the potential for the public, patients and other professionals to be misled.

   b. **Flexibility.** The GMC would legitimately adopt a slightly different approach to programmes leading to a UK primary medical qualification as compared to those leading to a GMC Overseas or European qualification. For the latter we would develop guidance explaining how we apply *Tomorrow’s Doctors* in a non-UK context, but maintaining the same high standards we require of UK programmes.
c. **A better balance between the needs of the UK as a whole, and our role as regulator.** This model would enable us to provide (and be reimbursed in full for) a service which is valuable both to the UK higher education institutions and to the relevant overseas countries, without distorting our regulatory framework to fulfil a purpose for which it was never intended.

d. **Cost control and accountability.** We may wish to take the opportunity of establishing a dedicated overseas section as a distinct business entity within the GMC.

**Recommendation:** To agree that we should ask the Department of Health (England) to amend the Medical Act 1983 to enable the GMC to recognise undergraduate medical programmes delivered by UK universities overseas.

**Next steps**

19. We will need to consider how quickly the above arrangements can be put in place. It will be important that the proposed changes apply prospectively to students enrolling after the Medical Act is amended, and do not affect those already admitted under the existing arrangements. Pending the outcome of the Law Commission work on revising the legislative framework for professional regulators, DH(E) are minded to promote only those amendments to legislation by way of a Section 60 Order which address urgent issues of patient protection. The CHRE have recently advised DH(E) that our proposed changes in respect of overseas medical education do not meet that requirement. Although we are continuing to have discussions with DH(E) about the legislative timetable it does therefore seem that legislative change may be three to five years away. By then the first cohorts from Newcastle/Malaysia and St George’s/Cyprus will have graduated.

20. On an interim basis, we will therefore need to continue to provide quality assurance under current legislation, while pressing DH(E) to make the necessary changes quickly. We will also consider how best to meet the aspirations of non-EEA graduates from overseas programmes who choose to use provisional registration as a route to full registration but who may not be eligible to undertaken Foundation training in the UK and who (because they will hold a UK PMQ) are not eligible to gain full registration through sitting the PLAB test either. This would require them to undertake experience equivalent to a Foundation Year one doctor. To provide ‘belt and braces’ assurance, we might also include a requirement to pass an assessment equivalent to the PLAB test.

**Resource implications**

21. We incur substantial costs in quality assuring the overseas campuses of UK medical schools. Currently we rely on a contractual agreement with these schools to allow us to recover the additional costs (air fares, associates fees, hotels etc). A change to the law would enable us to recover all costs as of right - including staff time in the UK - and make our overseas quality assurance activities cost neutral.
Equality

22. As members have previously noted, the duty upon us to regulate UK medical education delivered overseas creates both ethical and practical challenges in the area of equality and diversity. The work undertaken to date with Newcastle/Malaysia indicates the difficulties facing medical schools seeking to apply our standards overseas because of the organisationally and culturally specific nature of medical practice. The context makes a real difference. The Undergraduate Board has had lengthy discussions of this issue, which have fed into our planning of quality assurance visits overseas. We will keep it under close review in the light of reports from quality assurance activities overseas.