



General  
Medical  
Council

Regulating doctors  
Ensuring good medical practice

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**4 – Outcome of Consultation on the Review of the Future Regulation of  
Medical Education and Training – Annex B**

**Final Report of the Education and Training Regulation Policy Review:**

**Recommendations and Options for the Future Regulation of Education  
and Training**

**18 March 2010**

## SECTION 1:

### Preamble

1. Each year nearly 7000 medical students graduate from UK medical schools. Doctors also come from all over the world to train and work in the nation's health care system.<sup>1</sup> These doctors have embarked on a professional career focused on applying their knowledge and skills for the benefit and wellbeing of their patients.
2. Whether they complete a training programme towards specialist (including general practice) registration or develop their careers in other ways, doctors must maintain and develop their knowledge and skills throughout their working lives. This requires hard work and dedication and is essential if the profession is to fulfil society's expectations of better health supported by high quality, safe services.
3. Many different agencies and individuals have a role in ensuring that these expectations are met: including regulators, teachers, doctors and other healthcare professionals, as well as employers and health service managers. Each has a responsibility to ensure that doctors are able to develop their knowledge and skills in a framework that places a high value on excellence. To pick up a theme from Sir John Tooke's report into Modernising Medical Careers<sup>2</sup> 'good enough is not good enough' for the training of doctors, there must be an aspiration for excellence.
4. This report, which has its origin in the aspiration for excellence that Sir John set out, considers what steps are required by the GMC to help meet this goal in its role as the single regulator of medical education, following the merger with PMETB.
5. The starting point of this review is an assertion of the value of training from the first day at medical school to the last day a doctor is in practice. This needs to be underpinned by an active regulator committed to standards that support excellence in education and training.
6. At the same time, this constant aspiration to excellence must be matched at a political level and throughout the healthcare system.
7. The landscape in which medical education and training take place is changing, and a number of different organisations have a role in shaping the environment in ways which affect doctors' careers and learning. The challenge for the regulator is to maintain standards within a framework that is robust but flexible enough to be applied regardless of the organisational

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<sup>1</sup> In 2009, 58% of new GMC registrants qualified in the UK, 23% were from the EEA and 19% were international medical graduates from outside the EEA.

<sup>2</sup> Professor Sir John Tooke, *Aspiring to Excellence: Findings and Recommendations of the Independent Inquiry into Modernising Medical Careers*, 2007.

changes that might take place within the UK health care system. This report seeks to help the GMC achieve this aim.

## **SECTION 2**

### **Background and Context**

8. In the final report of his independent inquiry into Modernising Medical Careers in September 2007, Sir John Tooke made the following recommendation:

‘PMETB should be assimilated in a regulatory structure within GMC that oversees the continuum of undergraduate and postgraduate medical education and training, continuing professional development, quality assurance and enhancement. The greater resources of the GMC would ensure that the improvements that are needed in postgraduate medical education will be achieved more swiftly and efficiently. To this end the assimilation should occur as swiftly as possible.’

9. The Secretary of State accepted this recommendation. Work is now well advanced to merge PMETB with GMC by April 2010.

10. Although the merger will bring regulatory responsibility for the whole of medical education and learning under one roof, this consolidation of functions will not, in itself, achieve the full benefits envisaged in Sir John Tooke’s report.

11. To ensure that those benefits are realised, the GMC, with support from PMETB, invited Lord Patel to lead a review of the current arrangements for the regulation of medical education and learning and make recommendations that would inform future policy developments by the GMC.

## **SECTION 3**

### **Introduction**

12. Regulators carry out their roles in different ways. Some focus on setting high level principles and standards, some are more concerned with quality assuring processes while others may pay greater attention to defining outcomes. In the past, the emphasis was on a uniform approach by the regulator towards the regulated. Today there is likely to be more emphasis on tailoring the regulation to perceived risks. However, there is no single, right way to approach this and the model adopted will often depend upon a range of social, economic and political factors. In the complex arena of healthcare, safe and effective services are increasingly dependent, not on a single organisation, but on the extent to which the different professionals and agencies work effectively together. The regulation and the provision of education and training needs to reflect this reality.

13. PMETB and the GMC have undertaken their regulatory roles in quite different ways, reflecting the different stages of education each body has responsibility for, the legislative environments and the history of each organisation. PMETB has tended to set detailed standards focussing on curricula, assessment systems and educational environment, and to have collected data by survey and inspection. The GMC has also adopted a standards approach, but historically set broader guidelines without the formal approval of curricula undertaken by PMETB. The GMC's quality assurance regime has reflected the needs of the undergraduate environment. Both organisations have achieved much (see Appendix A).

14. Although the case for merger referred to a continuum of medical education and training, that must not lead to a 'one size fits all' approach to regulation. Beneath the legitimate aim of continuity and coherence in the way that regulation operates across the different phases of doctors' careers, there are fundamental differences between the undergraduate, postgraduate and continuing practice stages of education and learning. The regulatory regime needs to acknowledge those differences where they are legitimate. The review did not, therefore, begin with any presumption that one model of regulation was better than another, nor have we subsequently heard any argument for creating a single methodology.

15. Instead, we have tried to identify those aspects of regulation and learning that are working well, those that might require strengthening or modification, and those areas where there are significant gaps in the current arrangements.

16. More important than any notion of a continuum is the need for doctors to possess the qualities, knowledge and skills to enter each new phase of their career. In the past these transitions have perhaps been addressed too lightly in the absence of a single regulator. The key questions here, therefore, are what is the regulator's role in ensuring that only those with the right

attributes can progress so that patients are protected, and how best can the regulator foster the development of those attributes?

17. Of course this is not a static environment. Since this review got underway, important steps have been taken to enhance the regulation of education and training. In July 2009 the GMC approved the revised version of *Tomorrow's Doctors* which sets out the standards and outcomes required for undergraduate training.<sup>3</sup> In October 2009 PMETB published its *Future Doctors Policy Statement* which aimed to identify practical solutions to some of the immediate and longer term challenges facing postgraduate medical education and training.<sup>4</sup> Exploratory work has also begun on the possible accreditation of doctors' capabilities at defined points in their careers (often referred to as the credentialing of specialist competences).

18. Further steps have also been taken towards the introduction of revalidation. In 2008, the GMC published its draft framework for appraisal and assessment. Structured around four domains derived from *Good Medical Practice*, this framework will form a key component of the annual appraisals which will inform doctors' revalidation. The medical Royal Colleges and Faculties have also used this framework as the basis for developing the specialty specific standards that doctors will have to meet for revalidation, and for describing the types of supporting information that they will need to produce to demonstrate, through appraisal, that they are meeting those standards. This work will clearly be crucial to the way in which doctors demonstrate continuing fitness to practise, through continuing professional development (CPD) and in other ways, after they complete formal training.

19. Alongside these developments is the wider healthcare agenda which is fundamental to the future of education and training, but which goes beyond the remit of this review of regulation. This includes the work undertaken through a range of organisations and initiatives. It encompasses the work of NHS Education for Scotland (NES), the Postgraduate Deanery in Wales, the Northern Ireland Medical and Dental Training Agency (NIMTDA), and Medical Education England and its consideration of the Foundation Programme (and a parallel review in Scotland). It includes Lord Darzi's recommendations for developing the health workforce in England in *A High Quality Workforce: NHS Next Stage Review*<sup>5</sup>. Among other significant changes is the increasing diversity in the way health services are organised across the UK.

20. We have taken account of this wider environment and particular initiatives where they have begun to address gaps in existing regulatory arrangements, but have not revisited them or attempted to pre-empt the outcome of ongoing work in these and other areas.

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<sup>3</sup> *Tomorrow's Doctors: Outcomes and standards for undergraduate medical education*, GMC, 2009.

<sup>4</sup> *Future Doctors – A statement on the future of postgraduate medical education and training*, PMETB 2009.

<sup>5</sup> *A High Quality Workforce: NHS Next Stage Review*, Department of Health, 2008.

21. This report is about what the GMC must achieve as the regulator of medical education and training, but it cannot carry out its task alone. The GMC sets the standards and the framework for realising that aspiration for excellence referred to by Sir John Tooke, but it must work with others to ensure delivery.

22. The report does not offer a detailed prescription for the future regulation of medical education and training. Rather, it attempts to identify areas where regulation may be enhanced and options for how this might be achieved. It will be for the GMC to decide how and if it wishes to take these recommendations forward, some of which may require legislative change.

## SECTION 4

### Executive summary

23. This review looks at the role of the regulator in medical education and training. But the regulator is only one player in the complex healthcare environment required to develop and foster the skills and commitment of doctors throughout their careers. All those involved must fulfil their responsibilities if the UK is to provide world-class training to support a world-class health service. For its part, the GMC must enhance links with the other key interests: patients, the profession, providers of training and other regulators. **[Report section 6]**

24. Although there are crucial differences in the stages of doctors' education and learning which need to be acknowledged, regulation should reach across and link those stages. One of the main challenges is to support doctors' transitions from one stage to another so that risks are minimised and learning maximised. This will require effective systems for the transfer of information across these different stages. **[Report section 7]**

25. Medicine is both a profession and a vocation. Its practitioners need to understand what it means to be a professional and to make a personal commitment to the standards and values that this implies. One of the goals of undergraduate medical education is to begin the process of induction into the profession by instilling a culture of professionalism<sup>6</sup> that will inform doctors' practice throughout their careers. It has been argued that the current undergraduate experience does not always achieve this and that student registration could be one way of fostering a sense of professional identity. However, we are not convinced this is the only way and it may not be the most cost-effective. The GMC should evaluate the effectiveness of its existing arrangements for engaging with students and how their professional identity is fostered by medical schools. **[Report section 9]**

26. Newly qualified doctors need to be able to deliver the same standard of care regardless of where they qualified. Until now the GMC has set high level standards and allowed medical schools considerable flexibility in the way those standards are met. The revised edition of *Tomorrow's Doctors*, published in 2009, is much more detailed in terms of the content and outcomes required of undergraduate medical education. The GMC must evaluate the effectiveness of the new requirements in delivering outcomes that are consistent and reliable to determine whether further measures are needed to achieve these ends. **[Report section 10]**

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<sup>6</sup> Definitions of professionalism are many and varied. The Royal College of Physicians Working Party Report of 2005, *Doctors in society: Medical professionalism in a changing world* defines medical professionalism as 'a set of values, behaviours, and relationships that underpins the trust the public has in doctors'. The GMC's guidance to doctors, *Good Medical Practice* describes that professionalism in action.

27. Regulatory responsibility for the Foundation Programme is currently split between the GMC and PMETB. Although the two organisations have worked well to co-ordinate activities, the forthcoming merger will provide opportunities for rationalisation of the regulatory regime and adoption of appropriate practice. **[Report section 11]**

28. However, other anomalies with the regulation of the Foundation Programme remain to be addressed. Doctors in the first year of their foundation training may be working many miles from the medical school which is formally responsible for their training. This leads to lack of clarity over responsibilities. Equally unsatisfactory is the lack of any clear regulatory outcome required from the second year of the Foundation Programme. **[Report section 11]**

29. The regulation of postgraduate education and training has improved considerably in recent years. Following an initial period of turbulence, PMETB has established well regarded curricula for specialist (including general practice) training. We have found little appetite to overhaul this work. **[Report section 12]**

30. Nevertheless, there remain important areas which should now be taken forward. The GMC should develop a framework for the accreditation of trainers. It should also look at the case for accrediting the environments in which education and training takes place, in addition to approving posts and programmes as currently undertaken by PMETB. **[Report section 12]**

31. Above all, the GMC should develop a regulatory framework for the education and training of doctors in career posts. Such a framework would not only be in the interests of the doctors concerned (who are often disadvantaged by limited access to training and CPD opportunities), it could also provide reassurance that these doctors are meeting national standards overseen by the regulator. **[Report section 12]**

32. The public and employers must have confidence in the medical registers, and in the fitness to practise of doctors entering those registers. One factor militating against this is the lack of equivalence between the standards required of UK and EEA doctors entering the specialist and GP registers. The GMC should explore how this might be addressed. In particular, it should consider whether there is a case for uncoupling the completion of specialist (including general practice) training from the decision to allow a doctor onto the specialist or GP register. **[Report section 13]**

33. The GMC should also examine, with the Department of Health, the current legislative anomaly that makes it possible for doctors not on the specialist register to take up locum consultant posts. **[Report section 14]**

34. At the conclusion of specialty or GP training, doctors have most of their careers ahead of them. Participation in CPD is therefore key to maintaining and further developing competence and performance. In 2004, the GMC

issued guidance on CPD, but its regulatory role to date has been largely passive. **[Report section 15]**

35. Revalidation is intended to provide a new focus for ensuring effective and appropriate CPD for all doctors but this will require the GMC to re-examine its role in this area. At the very least, the GMC should provide clear guidance on what doctors will be required to do to keep up to date for the purposes of revalidation, and the role of CPD within that. At the same time, the GMC will need to recognise the individual nature of CPD and avoid rigid requirements which may undermine what is most valuable for individual professionals. **[Report section 15]**

36. The merger of PMETB with the GMC should enable the consolidation of good practice from both organisations and the GMC will no doubt want to build on this. In particular there is a need to consider: whether there are adequate mechanisms for identifying and addressing emerging problems in training institutions; the way in which quality assurance needs to develop to reflect the recent changes to *Tomorrow's Doctors*; the important role of employers in quality assurance; and a review of the funding model for quality assurance. **[Report section 16]**

37. More broadly, the GMC should re-examine the current focus on assuring the quality of the processes used for training doctors. Instead, it should consider placing greater emphasis on outcomes and the quality of the individual trainees produced by those processes. What matters to patients is the quality of the doctors who treat them, not the processes by which they were trained. **[Report section 16]**

38. This report contains 27 recommendations. Some of them point to a clear course of action. Others invite reflection by the GMC or offer options for further work. If adopted, a number of the recommendations will require changes to UK legislation. It will be important to ensure that the statutory framework within which the GMC must operate gives it the flexibility to innovate and adapt to changing needs. **[Report section 17]**

## **SECTION 5**

### **Working methods and approach**

39. The review has proceeded in three phases. Preliminary work during the latter part of 2008 concentrated on clarifying the scope and priorities for the review and gathering information. This began with a 'Chatham House' style round table discussion and a series of interviews with individual stakeholders. The second phase involved consideration by a small working group of the views and information collected (see Appendix B). The emerging views of the working group were then subject to debate within a wider reference group of stakeholders. The third and final phase of the review will involve public consultation on the conclusions of this report.

## **SECTION 6**

### **Approach to education and training**

40. The purpose of the GMC is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. One of the GMC's main functions is to promote high standards of medical education and in doing this its primary focus must be to ensure that the needs of the public are met. Patient safety must be the overriding priority at all stages of medical education and everywhere that training takes place.

41. If the GMC is to meet the needs of the public, it must engage effectively with patients and their representatives, employers, those who provide medical education as well as medical students and qualified doctors.

42. The GMC has the task of setting standards for education and training, but it is the NHS and other UK health services which, for the most part, undertake delivery of care and provide the context for training. The way in which health care is delivered varies in different parts of the UK and it is vital that the GMC has a strong relationship with all providers of medical education and training, including those at the undergraduate level. Where regulatory functions have been delegated to the undergraduate schools, postgraduate deaneries and local education providers, there must be clear lines of responsibility and accountability.

43. For their part, those responsible for funding and providing medical education must ensure that there are adequate resources and the culture necessary to support high quality training and meet the standards set by the GMC. The UK will only provide first rate medical care if it also provides first rate training for those who deliver that care. If this is to be achieved it will require a health care system which values education and training. Over the next few years when resources will be stretched this could be the greatest challenge to achieving excellence – it will also be a major challenge to the GMC as it seeks to maintain and improve standards.

44. In relation to postgraduate training, where there are failings in delivery the GMC, like PMETB before it, will not wish to use withdrawal of training recognition as its first option because patients rely on trainees to deliver day to day care. But the GMC must be prepared to highlight deficiencies and work with hospitals, GP practices and other settings to ensure that the required changes are carried through to avoid such a sanction.

45. PMETB has shown how this can be done, building relationships with those who provide training, as well as with professional and educational bodies such as the medical Royal Colleges. These relationships are supported by a robust system of quality assurance which gives the regulator the leverage to facilitate change and improvement where it is needed.

46. It will be crucial for the GMC to foster effective relationships with the system regulators in all parts of the UK if it is to assure the quality and influence the future delivery of postgraduate training. This will require better sharing of information and coordination between regulators so that service failures likely to have an impact on training can be identified quickly, acted upon and institutions held to account.

47. There may also be lessons to be drawn from PMETB's experience in establishing a more direct relationship with doctors. PMETB's trainee and trainer surveys offer one way of achieving this. The introduction of revalidation will require the GMC to engage with individual doctors throughout their careers in a way that it has not needed hitherto. We note that it is already considering the introduction of an annual return from doctors to support this work. The GMC should consider how it might use this more direct engagement with doctors to gather information to support better regulation of education and learning throughout their careers.

48. The GMC should also consider how some of the structures emerging to support revalidation, such as the Regional Medical Regulation Support Teams, might be used to support better regulation of education and training and identify emerging problems. There are synergies between good quality education, training and CPD provision, and doctors' revalidation. The regulator has to make sure that mechanisms are in place to exploit this so that the different elements of regulation are aligned and work together.

49. Finally, the GMC should look at options for drawing public attention to good practice and highlighting deficient practice by training bodies.

**Review recommendation 1:** The review welcomes the priority placed on protecting the public within the GMC's recent strategic plan<sup>7</sup>. The GMC should set out how the merger of the GMC and PMETB will benefit patients and what steps are in place to realise these benefits within a fully integrated regulatory framework for doctors.

**Review recommendation 2:** In integrating education and training into the regulatory framework the GMC should demonstrate robust mechanisms for engaging with and involving the public and taking account of the patient experience.

**Review recommendation 3:** Following the merger the GMC should clarify and strengthen its relationships with all its key interests, including education and training commissioners and providers and the system regulators, to ensure that it can fulfil its new responsibilities to be a robust and effective regulator across all stages of education and training.

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<sup>7</sup> *The Corporate Strategy*, GMC Council Paper December 2009.

## SECTION 7

### Understanding the ‘continuum of medical education and training’

50. Sir John Tooke’s report identified the potential benefits of bringing the regulation of medical education and training under the GMC. But it does not follow that the regulation of undergraduate and postgraduate training should or could be organised in the same way. Undergraduate and postgraduate training operate in different arenas, have a different focus and engage different interests, albeit with the same overarching aim of serving the needs of patients. Where there are shared interests, such as the development of effective trainers, the GMC should be able to demand the adoption of consistent national standards.

51. The continuum is vital in the continuity that should be experienced by every trainee as he or she moves through each phase of training, building on their professional development, skills and competencies and doing this within the overarching principles of *Good Medical Practice* which apply to all doctors and which should inform each phase of training.

52. To realise the benefits of this continuity, information and insight needs to be carried from one phase to another. Information about the strengths and weaknesses of individual trainees must be passed from the undergraduate phase into the workplace and so on, throughout a doctor’s career. If trainees are simply signed-off by the supervising institution or consultant at the end of each phase, that knowledge will be lost. One advantage of a single regulator is the opportunity to improve the transfer of trainees’ developmental needs at each stage in their career progression. To inform this the GMC will need to define nationally agreed data sets.

53. There is also a need to improve the transfer of information beyond the individual trainee. The requirements for each stage of training need to be informed by the experience of those dealing with the next stage. For example, undergraduate training should be informed by the experience of those involved in the Foundation Programme and their views about the fitness for purpose of the graduates entering Foundation training. Likewise, the experience of those involved in specialty training needs to inform the organisation and regulatory requirements of Foundation training. Bringing medical education and training under the auspices of a single regulator should facilitate this transfer of learning across the different phases of training. It has the potential to add value and create a continuum which links the distinct phases of education and at the same time strengthens the separate elements.

54. The ability to track individuals and groups of individuals through all stages of training (on the basis of agreed data sets) will be important in helping to identify individual and systemic problems. Medical schools and deaneries can make an important contribution to this by collecting

demographic and performance data that will help the GMC identify trends and emerging problems among trainees.

**Review recommendation 4:** The GMC should establish a national working group of key interests to address issues arising from the transitions between the different stages of education and training, including the steps it might take with others to facilitate the more effective transfer and co-ordination of information about curricula, assessments and individuals across the different stages. This will build on the work already begun by others in this area.

**Review recommendation 5:** The GMC should work with others to identify and collect nationally agreed data sets to inform its processes and validate the outcomes of its regulatory activities. It should also consider how technology might be used to support this.

## SECTION 8

### Begin at the beginning: selection into medical school

55. Medicine is a vocation.<sup>8</sup> It demands more than the acquisition and practice of a set of knowledge and technical skills. Some of those interviewed during the scoping phase of the review said that entering medicine should involve giving a commitment to that vocation. Some interviewees argued that careful consideration should be given to strengthening the GMC's role in the arrangements for selection into medical schools.

56. As the body responsible for regulating those entering the profession the GMC clearly has a stake in ensuring that successful applicants possess or have the potential to develop the qualities required to be good doctors. The question our review had to consider was whether the regulator has a role in trying to ensure those qualities by influencing selection into medical school as suggested by some of those interviewed.

57. The law currently gives the GMC no locus in this area and it is our view that it is not for the regulator to usurp the role of the medical schools by determining who is admitted to a particular medical course. Nor is it desirable or realistic for the regulator to seek homogeneity in a profession whose members require a diverse range of skills and attributes. Moreover, we are not aware of any evidence to show that it is possible to identify, at the point of selection, traits which might reliably point towards future dysfunction or success as a doctor. The only reliable, if incomplete, predictors of success are academic attainment and motivation, and such factors are highly contaminated and may be stable or trainable. This makes prediction on the basis of a range of discrete variables a risky strategy, particularly given that medical schools must provide graduates who can train and perform in highly disparate specialties.<sup>9</sup> This review has therefore concluded that the role of the regulator is to satisfy itself that the processes used by medical schools are fair,<sup>10</sup> and set the standards and outcomes that students must attain rather than specifying the pre-existing qualities they must have on entry to medical school.

58. But it is clearly important that those considering a career in medicine understand the nature of the profession and the environment that they would be entering. Medical schools and UK health service employers (as the principal recipients of medical graduates) have an important role in promoting awareness and understanding of what medicine is about.

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<sup>8</sup> Royal College of Physicians. Medical Professionalism in a changing world: Report of a Working Party; Royal College of Physicians of London; 2005; p14.

<sup>9</sup> I C McManus, Eleni Smithers, Philippa Partridge, A Keeling, , Peter R Fleming. Learning in practice: A levels and intelligence as predictors of medical careers in UK doctors: 20 year prospective study. *BMJ* 2003;327:139-142 (19 July); Eamonn Ferguson, David James, <sup>b</sup>, Laura Madeley.

Learning in practice. Factors associated with success in medical school: systematic review of the literature. *BMJ* 2002;324:952-957 ( 20 April ).

<sup>10</sup> Tomorrow's Doctors, Domain 3.

**Review recommendation 6:** The GMC should not seek to extend its regulatory role into selection for undergraduate training.

## SECTION 9

### Undergraduate years

#### *Progression, professionalism and student fitness to practise*

59. *Good Medical Practice* sets out the principles and values on which good practice is founded; these principles together describe professionalism in action. *Good Medical Practice* also provides the template for the standards and outcomes which medical graduates are expected to achieve, as set out in *Tomorrow's Doctors*. It is unrealistic to expect students who have still to enter the profession to display in full the professionalism described in *Good Medical Practice*, but they should be learning to demonstrate those qualities in the way that they practise. The three key outcomes of *Tomorrow's Doctors* are that students should acquire the attributes of the doctor as a professional, as a practitioner and as a scholar and scientist.<sup>11</sup>

60. As part of their progression through training, students need to be helped to understand where their strengths and weaknesses lie in these areas, supported by good career guidance. For the small minority who are unable to demonstrate the necessary attributes, there must be the opportunity of a clear exit route from medical training into other career options.

61. The questions for this review were what steps the GMC needed to take to ensure the acquisition of that professionalism, or appropriate induction into the profession, during the undergraduate years and how the GMC should monitor the extent to which that is being achieved.

62. It has been suggested that introducing some form of student registration could contribute to the development of a sense of professionalism. The idea is that a register would clarify the responsibilities of medical students, define appropriate boundaries for behaviour and help to establish professional identity. It has also been argued that student registration would help medical schools deal robustly with university disciplinary regimes which regard academic competence as more important than considerations of professional behaviour and the public interest. On this, however, there is some evidence that schools have been able to adapt their procedures to deal with fitness to practise issues and that they have benefited from the new guidance developed by the GMC in partnership with the Medical Schools Council *Medical Students: Professional Values and Fitness to Practise*. For example, six of the medical schools visited in the GMC's 2008/09 quality assurance cycle reported that they had made or were making some changes as a result of GMC's guidance and a further 14 schools reported in their 2008 Annual Return to the GMC that they had or planned to make changes that year.

63. The 'public interest' argument for student registration gains weight as student contact with patients increases during the course of their training. It

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<sup>11</sup> *Tomorrow's Doctors*, Outcomes 3.

may be that the case for more direct regulatory engagement with students is stronger in the later years of undergraduate education, signifying a step change in responsibility as individuals move closer to qualification as a doctor. This may become more relevant in the light of the increased focus in the revised edition of *Tomorrow's Doctors* on the importance of patient contact during undergraduate training.

64. In section 16 of this report, we recommend that the GMC quality assurance processes place greater emphasis on individual trainees. Closer regulatory engagement with students may be one means of achieving this.

65. The GMC considered the issue of student registration in 2007 but, at that time, concluded that the potential benefits were outweighed by the disadvantages. Instead, it opted to pursue other means of instilling an understanding of regulation and commitment to professionalism. These have included road shows to encourage debate among students about the concept of professionalism, publication of guidance on professional values and fitness to practise, actively seeking student participation in policy consultations and presentations at medical schools.

66. The GMC will wish to evaluate the effectiveness of its existing methods of student engagement and also consider whether there are other ways of supporting the development of professional behaviour, values and identity.

**Review recommendation 7:** The GMC should evaluate the effectiveness of its existing arrangements for engaging with students.

## SECTION 10

### Outcomes and entering the profession

67. *Tomorrow's Doctors* provides the framework of principles and outcomes expected from undergraduate medical education. Medical schools enjoy flexibility in the development of curricula to meet those outcomes. At the same time, there is a need for a degree of consistency and standardisation in educational outputs. Newly qualified doctors need the ability to deliver the same standard of care regardless of where they qualified. The review heard a range of views about the readiness of new graduates to enter the workplace.

68. Information gathered from interviews during the first phase of the review pointed to a perceived lack of standardisation in the competences of new graduates and a lack of readiness to enter the workplace. These views were supported by a Skills for Health study, undertaken to support the revision of *Tomorrow's Doctors*, which referred to a 'lack of confidence and competence in clinical-decision making, clinical procedures and prescribing in practical situations, lack of understanding of the NHS and how it works'.<sup>12</sup> It is not the role of the regulator, nor is it realistic, to attempt to produce doctors who are the "finished article" from the day of graduation. These doctors are still in the earliest stages of their training. Nevertheless, there needs to be a shared understanding of what is expected of the new graduate both in terms of service contribution and as they enter Foundation training. The GMC has sought to address such concerns in its recent revision of *Tomorrow's Doctors* by creating a more effective bridge between the undergraduate years and the workplace – it has also sought to bring greater consistency to the standards and outcomes delivered by undergraduate training.

69. Arguments have previously been advanced that there should be a national assessment that would provide 'objective reassurance to the public that the quality of medical education received by their doctor was high and consistent, irrespective of their place of qualification'.<sup>13</sup> There would be both potential benefits and drawbacks in introducing a national assessment. We noted that when the GMC consulted on strategic proposals for assessment in 2006 there was only limited support for the idea at that time.

70. In the course of this review we have found support for more robust, clearer and consistent outcomes that will enable the UK health services to place reliance on the quality of graduates, regardless of their place of qualification. We have encountered support in some quarters for a single national assessment as a way of delivering that. However, the means should be secondary to the end. Before considering a solution that would be costly and, in the short term, disruptive, it would be sensible for the GMC first to evaluate the impact of its 2009 revision of *Tomorrow's Doctors*. This will enable it to decide whether further measures are needed to ensure that all

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<sup>12</sup> Skills for Health. Junior Doctors in the NHS: Preparing medical students for employment and post-graduate training; Skills for Health, 2009, p3.

<sup>13</sup> Chief Medical Officer for England, Good doctors, safer patients, Department of Health, 2005, p195.

new graduates possess a common core of competences. The enhanced annual returns provided by medical schools to the GMC are one way in which the GMC may be able to begin to take an early view, without having to wait until the roll-out of the new requirements has been completed.

**Review recommendation 8:** The GMC should evaluate the impact of the 2009 revision of *Tomorrow's Doctors* with a view to considering the need to enhance the consistency of outputs from undergraduate medical education and, if appropriate, how that should be achieved. It should also consider whether the changes introduced in undergraduate training as a consequence of *Tomorrow's Doctors* have impacted on the needs and requirements of Foundation training.

## SECTION 11

### Foundation training

71. The foundation years form an important link between undergraduate medical education and specialist (including general practice) training. The Foundation Programme provides a course of training in a variety of healthcare settings and specialties. The two years of the programme provide an opportunity for trainees to develop their clinical skills in closely supervised settings.

72. The Foundation Programme is a relatively new feature of medical education, introduced by the current government in the context of modernising medical careers. As noted earlier in this report, the Foundation Programme is currently the subject of review in both England and Scotland. Around this, a number of people have expressed the view that aspects of the current regulatory arrangements are unsatisfactory. The GMC regulates the first year to the point of full registration and PMETB regulates the second year. Both regulators have worked together closely on the quality assurance of the foundation programme (QAFP). The merger will bring regulatory responsibility under one organisation and this provides an opportunity to review the current arrangements.

**Review recommendation 9:** Having brought the regulation of the foundation years under one regulator, the GMC should review the quality assurance process to ensure the benefits of the merger are given effect in the Foundation Programme.

73. The arrangements in part reflect European law which states that basic medical training shall comprise at least 5,500 hours or six years of study which must be provided by or under the supervision of a university. This typically comprises the five years at medical school and first year (F1) of the Foundation Programme. For this reason medical schools maintain responsibility for trainees up to the point of full registration. At that point the responsibility transfers to the postgraduate deanery. However, deaneries manage the whole of the Foundation Programme through their Foundation Schools. Nearly 40% of UK medical graduates do not start the Foundation Programme in the Foundation School associated with the medical school from which they graduated.<sup>14</sup> For trainees undertaking the Foundation Programme many miles from their medical school they might have little contact with the body formally responsible for signing them off for full registration. This arrangement leads to anomalies over responsibility for the training within the foundation years.

74. One anomaly is that while there is a single set of standards (the Standards for Training for the Foundation Programme) for the whole Foundation Programme, outcomes are defined by the regulator for the first

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<sup>14</sup> The UK Foundation Programme Office, Foundation Programme Annual Report 2009 National (UK) Summary.

year only. This is because doctors must demonstrate these outcomes to be eligible for full registration with the GMC at the end of the first year of the Foundation Programme. For the second year, the curriculum does contain a clear statement about the outcomes that are expected to be achieved but these outcomes are not set down by the regulator. However, to progress to specialist training there is a requirement to demonstrate the competences required to complete Foundation training.

**Review recommendation 10:** The GMC should consider whether further steps are required to ensure that processes for signing off trainees for full registration are robust. This should include consideration of whether the responsibilities of medical schools should end at the point of student graduation.

**Review recommendation 11:** Subject to the outcome of the current review of the Foundation Programme, the GMC should define the outcomes required to complete the second year of the Programme, in the same way as it defines outcomes for undergraduate medical education.

## SECTION 12

### Postgraduate education and training

75. Interviews and discussion during the course of the review highlighted the progress that has been made during recent years in bringing greater coherence to postgraduate education and training across specialist (including general practice) training. The work undertaken by PMETB in establishing curricula has been fundamental to what has been achieved. We found little appetite to overhaul this and a consistent view that it needed to be given the chance to 'bed in'.

76. However, there are two areas which require further development. The first concerns the place of the training environment and whether it should be more clearly recognised within the regulatory framework. The second relates to the need to establish a regulatory framework for the oversight of education and training of those doctors not in a programme leading to the award of a Certificate of Completion of Training (CCT).

#### *The education and training environment*

77. Currently postgraduate training is delivered by a wide variety of local education providers. PMETB is required to approve the training in posts and programmes that lead directly to the award of a CCT for specialist registration. A major component of the PMETB's quality assurance work is the approval of such posts and programmes. This approach, which is set out in legislation, has the benefit of detail with over 1000 approvals listed on the PMETB website.

78. There is a perceived inequality between training in primary care, where GP trainers are approved as a prerequisite to the provision of training, and training in secondary care where only posts and programmes must be approved. The differences extend to the contracts for trainers which are formal and funded in primary care but not in secondary care. While acknowledging the differences between these contractual arrangements, which are not a regulatory responsibility, the learning environment and the systems of supervision should be the same in educational terms. Further, those who are recognised as trainers need to be allocated the time and resources necessary for their role, and must be accountable for the way they carry it out.

79. Some have suggested to the review that postgraduate trainers in secondary as well as primary care above a certain level of supervisory responsibility should be individually accredited. In its policy statement, *Future Doctors*, PMETB committed to putting in place a process for the accreditation of trainers, including those in a hospital setting. This approach would take as its starting point the existing PMETB standards for trainers, applicable to all clinical and education supervisors, which help to provide a regulatory framework for this role, with the requirement that the standards must be met

by January 2010. Work towards the accreditation of trainers should build on that already undertaken by the Academy of Medical Educators and others in this area. It must also be proportionate and avoid imposing regulatory burdens which might deter good trainers from involvement in teaching and training.

80. A further step which would bring together posts, programmes and trainers, as well as the broader training environment, would be to accredit the education and training environment as a whole. This would replicate part, but not all, of the current practice in primary care training. By considering the institution as opposed to elements of the training, all the factors which contribute to create an excellent and safe learning environment can be considered. Accreditation of the environment may also have the benefit of bringing greater recognition to training, enabling healthcare providers which have been selected as training institutions to be recognised for excellence.

81. There are further significant issues which would need to be considered. For example, recognition of trainers might not be feasible for some specialities where training is undertaken in the independent sector, such as pharmaceutical medicine or occupational health. There are also significant interdependencies with the UK health services to consider. Currently, much of the health service is reliant on trainees to deliver the service. If training is no longer delivered in a particular location this could have a major impact on service provision, although close cooperation and shared planning between training and service could mitigate this risk. Any approach should recognise the difference between primary and secondary care, taking into account the different working practices.

**Review recommendation 12:** Having implemented the standards for trainers and evaluated their role and effect, the GMC should develop a framework for the accreditation of trainers.

**Review recommendation 13:** The GMC should work with others to explore the benefits and weaknesses of accrediting or approving the education and training environment in addition to approving posts and programmes.

*The framework for education and training not leading to specialist or general practice registration.*

82. Considerable progress has been made in the regulation of specialist (including general practice) training leading to the award of a CCT. However, there are up to 20,000 doctors practising as specialty, trust grade, staff grade and associate specialist (SAS) doctors who are not on CCT training programmes or do not hold CCTs. These doctors are fundamental to the provision of care in the UK health services. All will have undertaken some training after initial registration. For example, the BMA suggests that although staff grade doctors are not trainees on formal training posts, such doctors will have undertaken some training and are likely to have a professional qualification, or part of one, from the relevant medical Royal College or

Faculty.<sup>15</sup> Locum consultants may not have completed a training programme leading to specialist registration but will have satisfied their employer that they are of an adequate standard and able to fulfil the role.

83. It is unacceptable that the current system of statutory regulation does not have a framework for doctors in career posts who are working outwith training programmes that lead to specialist or general practice registration. Whilst employers have a responsibility to ensure that the doctors they employ are competent, the public has a right to expect that doctors should have completed high quality training to develop and maintain competence.

84. There is a need, therefore, for such doctors to be able to demonstrate their attainment against clear standards. This is in the interests of the doctors who are undertaking these roles, of whom a disproportionate number are women or from minority groups. Such doctors are often disadvantaged by the current arrangements because of limited access to training and CPD opportunities. Tackling this will also benefit employers and the public by demonstrating that these doctors are meeting nationally agreed standards overseen by the regulator. Professional organisations such as the medical Royal Colleges should be responsible for developing appropriate specialty specific standards.

85. A number of initiatives are already underway which have the potential to achieve this. In particular, the specialty standards that have been developed by the medical Royal Colleges and Faculties to support revalidation will apply to all doctors working in the relevant specialty. By drawing on evidence from individual practice to revalidate against those standards, doctors in staff and associate specialist grade posts will be able to demonstrate that they are practising to the appropriate level. The GMC will be consulting on those standards this year. In addition, we note that the GMC is looking at how the use of credentialing within revalidation might support the more effective regulation of this group of doctors.

**Review recommendation 14:** The GMC should enhance the regulatory framework for education and training for doctors in career posts and not currently in specialist (including general practice) training programmes leading to a CCT.

86. An important aspect of the existing arrangements for doctors not in training has been the introduction of the equivalence routes to registration through Article 11 and Article 14<sup>16</sup>, leading to the award of a Certificate of Eligibility for Specialist Registration (CESR) or the Certificate of Eligibility for General Practice Registration (CEGPR). This process means that those achieving registration have demonstrated that their qualifications or training, together with their experience, are equivalent to the standard of a CCT or CCTGP. This route to registration has enabled many

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<sup>15</sup> [http://www.bma.org.uk/patients\\_public/whos\\_who\\_healthcare/glossdoctors.jsp](http://www.bma.org.uk/patients_public/whos_who_healthcare/glossdoctors.jsp)

<sup>16</sup> Articles 11 and 14 of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003.

experienced and knowledgeable doctors to be registered as specialists or GPs and make a contribution at a more senior level.

87. The General Practice route to the register has been in place for some time and is well understood and accepted, but the specialist route is relatively new. Concerns have been expressed about the complexity of the CESR process. However, the administration of applications has improved and the lengthy delays found in some specialties have now largely been eliminated. PMETB recently completed an extensive review of the CESR process which considered the whole CESR application process from start to finish. The review working group made a number of significant recommendations for improving the administration and evaluation of applications, many of which have already been acted upon. Nevertheless, the merger should provide impetus for the GMC to build on this progress and use its greater resources and experience to find opportunities for further improvement.

88. During this review some have expressed concern about the ways in which CESR and CEGPR cases are evaluated. This has touched on the consistency of the approach and the importance attached to documentary evidence of practice as opposed to demonstration of expertise. Whether or not these concerns are well founded needs to be investigated further.

89. Some of those submitting views to the review expressed concern that the CESR is not recognised by employers and other members of the profession as truly equivalent to the CCT. It has been suggested that removing the distinction between the name of the CESR and CCT would help overcome this. However, this would be difficult to do given the requirements of the European legislation.

**Review recommendation 15:** Following merger, the GMC should review the processes leading to the award of CESRs and CEGPRs to ensure they are fair, efficient and fit for purpose, and that the processes continue to ensure standards are maintained.

#### *Selection into specialist training*

90. Current legislation gives the regulator no role in the selection of trainees into specialist training. It does, however, require the regulator to set standards for entry into specialist training. The regulator's powers are limited to ensuring that, in principle and subject to proper implementation, selection processes are capable of distinguishing between those candidates who are qualified to undertake such training and those who are not. The current legislation also requires the regulator to approve assessment systems.

91. However, since the current legislation was drafted, selection into specialist training has increasingly involved assessment techniques. For example, some specialties include applied knowledge and situational judgement tests as part of the selection process. As a result some argue that selection is now an assessment process, with high stakes for every candidate.

92. The issues are complex and touch on a range of issues, not least the nature of the appointment of junior doctors into the UK health services, given both the service and training aspects of working life. During 2009, a working group supported by PMETB has been considering whether selection into postgraduate specialty training leading to the award of CCT is a form of assessment.

93. The Working Group concluded that, in 2009, assessment instruments are used in most selection processes for entry into postgraduate medical training. The group therefore recommended that the GMC seek to ensure that regulations permit the GMC to have oversight of the assessments used in selection into postgraduate training.

**Review recommendation 16:** The GMC should note the recommendations of the Selection into Specialty Training Working Group report.

#### *Sub specialisation*

94. The use and development of both specialties and subspecialties has evolved. In addition to the 61 specialties recognised by the UK government there are 34 recognised subspecialties.

95. Although a CCT can be awarded in one of 61 recognised specialties, there are currently more than 300 specialties listed on the register. This anomaly arose in part because when the specialist register was first established the law enabled existing specialists to be included and because some specialties which were included have subsequently been decommissioned. Regardless of the history, the current position is neither clear nor transparent.

96. PMETB is currently reviewing the role of the regulator in subspecialty training, including the relationship between specialty and subspecialty training. The Board is considering how it approves different subspecialty training formats and how they can be effectively quality assured.

**Review recommendation 17:** The GMC should consider the outcomes of PMETB's review of subspecialties once the PMETB Subspecialty Training Task and Finish Group has completed its work.

## SECTION 13

### EU and international medical graduates

97. EC law on the recognition of professional qualifications sets out the minimum training requirements for doctors across the EEA.<sup>17</sup> Provided training satisfies those minimum requirements, member states are required by law to recognise the qualifications held by nationals of other EEA states. This means that for the purposes of doctors' eligibility to practise in the UK, the GMC has to treat EEA qualifications held by EEA nationals in the same way as UK qualifications. The GMC cannot carry out any assessment of the knowledge and skills of incoming EEA doctors who hold recognised qualifications. There is, however, significant variation between the training undertaken in different EEA countries. As a result the GMC is unable to ensure that all new registrants are of an equivalent standard to UK trained doctors. This clearly limits the effectiveness of the registers and the ability of the GMC to protect patients.

98. Given this shortcoming in current legislation it is all the more important that employers fulfil their obligation to ensure that any doctor they employ is fit for the job they are to undertake. Unlike the GMC, employers are able to evaluate the fitness for purpose of any doctor they employ provided that they do so in a way that does not discriminate unfairly.

99. But the GMC should also review its scope for action. In particular, it should consider ways of increasing the transparency of its registers. In particular it should look again at the possibility of uncoupling the completion of training leading to eligibility to take up consultant and GP posts, and inclusion on the specialist and GP registers. Eligibility for inclusion in those registers might come at a later stage, perhaps at the point of first revalidation following completion of training. The implications of such a reform would need further discussion with those affected, but uncoupling could provide a mechanism for continuing to meet EC requirements in relation to recognition of training while ensuring greater equivalence in standards at the point of entry to the specialist and GP registers.

100. At the same time it will be important to continue to address doctors' aspirations to work as consultants and GPs. This might be achieved by linking eligibility to take up these posts with completion of the CCT or relevant EEA qualifications rather than, as at present, inclusion in the specialist and GP registers.

**Review recommendation 18:** The public and employers must have confidence in the fitness for purpose of the registers, and in the fitness to practise of the doctors on the registers. The GMC should explore how it might ensure greater equivalence in the standards of doctors entering the specialist and GP registers. This should include

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<sup>17</sup> Directive 2005/36/EC on the recognition of professional qualifications .

consideration of the case for uncoupling inclusion in the registers from the certification process.

## SECTION 14

### Locums

101. As the law stands, a doctor must be included in the specialist register in order to take up a substantive appointment as an NHS consultant. There is no such requirement for a doctor taking up a locum consultant position. Patients have the right to be assured that any consultant responsible for their care has attained and demonstrated a common minimum standard of competence. The current situation cannot give patients that assurance and undermines the transparency and utility of the specialist register.

102. The position is in notable contrast with the requirements for working in general practice. With the exception of trainees, any doctor working in general practice in the NHS, including locums, must be on the GP register.

**Review recommendation 19:** Subject to consideration of the recommendation in section 13, any doctor undertaking a locum consultant post in the UK health services should have been accepted on to the specialist register. This should also ensure that there is consistency between specialist and GP registration.

## SECTION 15

### Continuing practice

103. At the conclusion of specialty or GP training, doctors have most of their careers ahead of them. For those in training, structures exist to support their progression. Once outside formal training programmes, the onus is on doctors to demonstrate that they are maintaining appropriate professional standards. The role of the regulator is to support them in doing this and to monitor that it is done.

104. *Good Medical Practice* requires doctors to keep their knowledge and skills up to date and encourages them to 'take part in educational activities that maintain and further develop' their competence and performance. In future, revalidation will provide a focus for that formative activity. These elements will be brought together through appraisal and continuing professional development (CPD) and through each doctor's personal development plan.

105. CPD has a number of benefits; it can support innovation and the development of new skills, encourage reflective practice, and may help to improve good practice or address deficient practice. More broadly, CPD should be about each individual taking responsibility for personal regulation and professionalism. CPD is a critical part of patient safety, helping to ensure that doctors are up to date and fit to practise, managing risk and, if necessary, highlighting areas of practice that require remediation.

106. By its nature, CPD must be tailored to the specific needs and interests of individuals and their practice. Specific outcomes may be hard to measure. If CPD is to be effective, it cannot simply be instrumental and narrow, based only on past performance. It must also predict future challenges. Indeed, it is important to recognise that CPD may not produce immediate and tangible benefit in terms of measurable outcomes or changes in behaviour. The regulator should, therefore, be extremely cautious before seeking to intervene directly in CPD through application of prescriptive requirements which may add little or no value and put effective practice at risk.

107. Nevertheless, the regulator does have a legitimate interest in CPD. Above all, this is about improving medical practice to bring about better patient care and CPD will be an important element within revalidation. Doctors will expect the GMC to provide clear guidance on keeping up to date for the purposes of revalidation and the role of CPD within that.

108. The GMC last issued guidance on CPD in 2004.<sup>18</sup> Since then, much has changed and the GMC should consider afresh how its regulatory role should be exercised in relation to CPD. As a minimum, the GMC should look

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<sup>18</sup> [http://www.gmc-uk.org/education/continuing\\_professional\\_development/index.asp](http://www.gmc-uk.org/education/continuing_professional_development/index.asp)

to build on the valuable work of the Academy of Medical Royal Colleges<sup>19</sup>, and develop core principles to underpin the role of CPD within revalidation. The GMC may also wish to consider how the outcomes of CPD can best be addressed or reviewed within local appraisal systems and the role of the GMC in the overall quality assurance of CPD and the process of appraisal.

109. There are other ways in which the GMC can add value in this area by supporting particular groups of doctors. For example, the report *Non UK qualified doctors and Good Medical Practice: The experience of working within a different professional framework* has recommended that the GMC should consider developing resources to assist such doctors in understanding and interpretation of *Good Medical Practice*. Providing a framework of principles for CPD may also be useful especially at points of known regulatory risk in doctors' careers, such as during key transitions in levels of responsibility.<sup>20</sup> Furthermore, the GMC should draw on its own experience from its work in standards and ethics, in fitness to practise and, in due course, from revalidation, and ensure that this informs its approach to CPD.

110. In taking forward any of these ideas, the GMC must proceed with due sensitivity to the individual nature of each doctor's CPD needs. In helping to strengthen the regulation of CPD as a whole, the GMC must be careful to preserve the value of CPD for individual professionals and support their own approaches to learning and continuing development. Above all, the GMC must avoid the prescriptive regulation of CPD and recognise the value of a personal approach tailored to the needs of the individual.

**Review recommendation 20:** The GMC should update its 2004 CPD guidance and re-examine how the regulatory role in CPD should be exercised so as to support doctors in meeting the requirements of revalidation and providing high quality care for their patients, whilst preserving the value of CPD for individual professionals.

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<sup>19</sup> The Academy of Medical Royal Colleges work includes the 10 Principles of CPD and core headings for CPD and further work is ongoing..

<sup>20</sup> Trudie Roberts, et al, Learning responsibility? Exploring doctors' transitions to new levels of medical responsibility: Full Research Report ESRC End of Award Report, RES-153-25-0084. Swindon: ESRC, 2009.

## **SECTION 16**

### **Quality assurance**

111. Protecting patients through effective quality assurance is at the heart of the regulator's business. Put simply, the purpose of quality assurance is to ensure that doctors emerging from training have the knowledge, skills and qualities that are required to protect and promote the safety of patients and the public.

112. The GMC and PMETB have operated in different arenas and under different legislation and thus have had to adopt slightly different approaches to quality assurance although both have focused on ensuring that the institutions delivering education and training are meeting the standards set by the regulator, rather than looking at outcomes and the attainments of individual trainees. Using evidence of good processes as a proxy for good outcomes is an understandable and well recognised methodology in quality assurance.

113. The approaches adopted by the GMC and PMETB have been driven, to some extent, by the legislative frameworks within which they operate. The law has required the GMC to maintain a list of recognised qualifications and PMETB to approve and publish posts and training programmes. This has inevitably steered both bodies towards the inspection of processes and systems but it does not preclude looking at outcomes.

114. The risk is that the regulator focuses more upon the process for training good doctors, than on whether that training produces good doctors. What matters for patients is the quality of the practitioner who treats them, not the processes by which they were trained. During this review it has been suggested that some new graduates do not feel equipped for work and that some CCT holders lack the necessary competences. This suggests that the GMC should focus more particularly on the individual and on outcomes.

115. Legislation must set out the GMC's duties and powers in terms of clear principles, but must not be so detailed and prescriptive that it hampers the regulator's attempts to improve standards and adapt to the changing needs of the healthcare environment. Legislation should give the GMC the flexibility and scope to develop modern approaches to quality assurance that will ensure that both individuals and institutions are meeting standards and that training programmes are fit for purpose. For example, the ability to recognise individual undergraduate programmes rather than the whole institution would create a more sensitive approach capable of recognising and acknowledging strengths in some areas while acting on weakness in other areas.

116. The review recognises the considerable achievements of the GMC's QABME process. This five yearly quality assurance cycle, coupled with the provision of annual returns following up recommendations, together with additional visits where concerns are identified, all provide a focus for medical

schools to maintain and improve standards. The process can also provide the necessary leverage to support schools in making improvements.<sup>21</sup>

117. We received some evidence of a lack of consistency and standardisation in the way that the QABME process operated in its early days.<sup>22</sup> We were mindful, however, that the learning taken from that initial QABME cycle has led to significant refinement in recent years.<sup>23</sup>

118. There is now an opportunity to build on this work. Although there are systematic mechanisms for identifying and addressing emerging problems in between QABME visits, consideration should be given to whether they are sufficiently effective. There is a range of options that might be considered, including reviewing the outcomes of basic medical education, foundation and specialty training to identify local trends, and requesting more detailed information on specific issues, such as assessment, where trends have been identified across providers.

119. Quality assurance places a burden on both the regulator and the regulated. It is therefore important that the process brings value by measuring the things that will matter most and not just the things that are most easily measured. The overriding objective must be to measure outcomes that will ensure graduates have the skills and qualities to enable them to become good doctors. This must be coupled with timely reports from the regulator that allow early and effective action where problems have been identified.

120. The revision of *Tomorrow's Doctors* completed in 2009 will require the GMC to revisit the way in which undergraduate medical education is quality assured and which aspects are quality-assured. The fact that *Tomorrow's Doctors* is more specific about the required outcomes from training should in turn lead to greater specificity and consistency in the QABME process and in the way it is carried out. The increased emphasis on clinical contact with patients during the undergraduate years should be reflected in the way in which these outcomes are quality assured.

121. The GMC should explore with the system regulators (in the four countries of the UK) how their respective regulatory regimes work together so that they do not duplicate or overburden the system but are mutually reinforcing. For example, this should cover the efficient and timely transfer of information between regulators about institutions which are failing to meet the required standards in education and training, including provision of the clinical context. Satisfactory fulfilment of these responsibilities should be a requirement for registration with the appropriate system regulator.

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<sup>21</sup> Quality Assurance of Basic Medical Education (QABME) Annual Monitoring Returns 2008/09 and responses to 2007/08 QABME Reports; GMC Undergraduate Board paper, item 7, 31 March 2009.

<sup>22</sup> J Grant, T Roberts, M Maxted, K Boursicot, K Chambers, S Kilminster, J Marshall. An Investigation of the Explicit and Implicit Purposes of *Tomorrow's Doctors* and an Analysis of the Impact of Possible Environmental Changes on the Knowledge, Skills, Attitudes and Behaviours Required of Medical Graduates; Open University Centre for Education in Medicine, 2007.

<sup>23</sup> Evaluation of the QABME Process 2006/07; GMC Education Committee paper, item 8, November 2009.

**Review recommendation 21:** Legislation should allow the GMC greater flexibility in the way it is able to satisfy itself that standards and outcomes are being met.

**Review recommendation 22:** The GMC should consider whether the existing mechanisms for identifying and addressing emerging problems between QABME visits could be enhanced.

**Review recommendation 23:** The GMC should consider further whether the current focus of its quality assurance activities upon institutional processes provides sufficient assurance of the quality of outcomes and individual trainees produced by those processes, and of their progress through training.

**Review recommendation 24:** The GMC should consider the implications of the changes to *Tomorrow's Doctors* for the future focus and methodology of its QABME programmes.

**Review recommendation 25:** The GMC should work with the systems regulators to ensure that those organisations providing education and training are held to account for meeting the required standards and outcomes.

122. Work is underway to examine how GMC and PMETB have approached quality assurance and to identify best practice. This work will also examine opportunities for greater consistency and how aspects of undergraduate and postgraduate inspection and assurance processes might be consolidated and better co-ordinated. As has already been noted, there is little appetite to overhaul fundamentally the framework established by PMETB. The fact that there are differences between the quality assurance tools used at different stages of education and training is not, in itself, important; but there should be common principles and purpose governing all stages. The regulator must also be mindful of the regulatory burden that quality assurance activities impose on institutions and be able to demonstrate the value such activities add in ensuring high quality outcomes.

123. Those involved in training and those affected by the outcomes of training must have confidence in the quality assurance regime. Proper engagement with employers and the profession is needed regarding what it is appropriate to expect of medical students and trainees. That engagement needs to be coupled with meaningful involvement in the quality assurance of training.

124. At present, both GMC and PMETB processes involve educators, academics, trainees, patients and employers. However, expressions of dissatisfaction from employers and supervisors about the outcomes of undergraduate training<sup>24</sup> and about the level of employer involvement in the

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<sup>24</sup> Skills for Health. Junior Doctors in the NHS: Preparing medical students for employment and post-graduate training, Skills for Health, 2009, p3.

quality assurance of education and training points to a need for greater employer involvement at all stages.

**Review recommendation 26:** Confidence in quality assurance processes and outcomes requires involvement of representatives of all key stakeholders. As the main recipients of trainees from medical school, the UK health services have an important role in the quality assurance of medical education and training.

125. At present, the cost of the GMC's quality assurance activities in undergraduate medical education and Foundation Year 1 is absorbed by the profession through the annual retention fee paid by all doctors to the GMC. However, around 30% of current GMC registrants have qualified outside the UK.

126. The cost of PMETB's quality assurance of postgraduate training has been supported by central government. This arrangement will not continue in the longer term following the merger of PMETB with GMC. A new funding model will therefore need to be determined across the whole of the GMC's activities.

**Review recommendation 27:** The merger of PMETB with GMC will necessitate a review of the funding arrangements for the quality assurance of medical education and training. The review of the funding model should start by defining all of the beneficiaries of the GMC's quality assurance activities.

## **SECTION 17**

### **Legislation**

127. We recognise that a number of the recommendations in this report would require changes to UK legislation before they could be implemented. It is important not to limit improvements to the regulation of education and training in the future simply because of the constraints imposed by legislation designed for an earlier time.

128. Although we have made a number of recommendations as to future policy, we have not detailed the precise legislative changes that we think would be required to bring these about. This will be a task for the GMC and government once they have reflected upon and developed the details of the proposed reforms.

129. We are conscious that the legislation which will merge PMETB with the GMC has, of necessity, been limited in its ambitions to enabling the merged organisation to continue to deliver its regulatory responsibilities in a seamless manner from day one of the merger. That was a right and proper approach to achieving the merger in a timely and effective manner. The inevitable drawback is that the amended Medical Act preserves some of the anomalies, rigidities and inconsistencies of the former system.

130. Yet the regulation of medical education and training, like other aspects of regulation, operates in a dynamic and fast changing environment. It will therefore be important to ensure that future legislation in this area will both address the shortcomings of the existing legislative provisions and give the GMC the flexibility it needs to adapt to changing needs in the future. This will put the organisation in a strong position to meet the expectations of its stakeholders in years to come.