
4b

To consider

Quality Assurance of UK Medical Education Delivered Overseas

Issue

1. The role of the GMC in relation to the delivery of medical education overseas by UK medical schools.

Recommendations

2. To acknowledge the GMC's current statutory duty to quality assure undergraduate medical education and training provided by recognised UK medical schools wherever that is delivered (paragraphs 13 – 34).
3. To endorse the principle of UK institutions working to support improvements in the standards of medical education and training worldwide (paragraphs 13 - 34).
4. To agree that it is inappropriate for the GMC to be required to undertake the quality assurance of medical education and training provided by recognised UK medical schools overseas and to seek legislative change to end this requirement (paragraphs 13 - 34).
5. To agree in principle the need for amending legislation to include saving and transitional provisions which will end our regulatory obligations overseas in an orderly, managed and equitable manner (paragraphs 36 – 39).

Further information

6. If you require further information about this paper, please contact us by email: gmc@gmc-uk.org or tel. 0161 9236602.

Background

7. This paper touches on two of the strategic aims contained in the 2010 Business Plan. Under Strategic Aim One we have undertaken to continue ‘to register only those doctors that are properly qualified and fit to practise’, while 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. The issue raised by the paper concerns the extent to which our statutory obligations are incompatible with these aims and with our role as a UK regulator.

8. During informal discussion on 20 May 2010 members were advised of initiatives by several UK medical schools to establish campuses outside the UK which would deliver undergraduate medical education and training leading to a recognised UK medical qualification. The most advanced of these was a proposal from Newcastle University Medical School (NUMS) to award a UK qualification to students studying at its campus in Malaysia. It was noted that Queen Mary College was pursuing a similar initiative in Bangalore, India, and Southampton University was developing plans to deliver both its qualification and a programme for provisionally registered doctors (the first year of the Foundation Programme) leading to full registration with the GMC, through a private hospital in Germany. This is not the first time such initiatives have been proposed. In the 1990s Sheffield University established links with a university in Malaysia which would have led to graduates who had pursued significant elements of their training outside the UK obtaining a UK primary medical qualification. In the event, this did not materialise.

9. Preliminary discussion recognised the value of supporting initiatives aimed at enhancing medical education overseas, but also the risks, opportunity costs and ethical difficulties for the GMC in attempting to regulate that education.

10. It was, nevertheless, clear from legal advice that we currently have a statutory duty under the provisions of the Medical Act 1983 (‘the Act’) to quality assure undergraduate medical education and training provided by recognised UK medical schools, regardless of where it is delivered.

11. In the light of this legal advice (which has recently been reaffirmed), in 2008 the GMC and the Medical Schools Council published joint guidance for medical schools on the quality assurance of UK undergraduate education delivered outside the UK. NUMS subsequently submitted plans to establish a campus in Malaysia and we have been working with them on the quality assurance of the education and training it will deliver.

12. Council members acknowledged that our statutory duty under the Act, coupled with the work already undertaken with MSC and individual UK universities, means that we cannot simply resile from our existing position. We must, and will, fulfil our statutory obligations. Nevertheless, members sought the opportunity to reflect further on our policy aims and how they should be delivered in the future.

Discussion

What the law says

13. Section 5(1) of the 1983 Act gives the GMC the general function of promoting high standards of medical education and co-ordinating all stages of medical education. Section 5(2) specifies how that over-arching function is to be discharged. This provides that the GMC must:

- a. Determine the extent of the knowledge and skill which is to be required for granting UK primary medical qualifications.
- b. Secure that the instruction 'given in or under the direction of bodies or combinations of bodies in the UK' to persons studying for such qualifications is sufficient to equip them with the necessary knowledge and skill.
- c. Determine the standard of proficiency required.
- d. Secure the maintenance of that standard.

14. Section 4 of the Act provides for the GMC to recognise 'bodies or combinations of bodies in the UK' that require from students a standard of proficiency conforming to that prescribed under section 5(2).

15. The salient point is that the legislation focuses on bodies 'in the UK'. The relevant location is where the body is based, not where the course is delivered. Provided that the body is based in the UK, and thus awards a UK primary qualification, the course can be delivered anywhere in the world.

16. It is also relevant that the legislation focuses on the medical school(s) rather than on any particular course or programme offered by the medical school(s). Thus we could not, for example, recognise the UK programme offered by a UK institution, but at the same time refuse recognition to the programme delivered overseas by the same institution. The institution or body must be recognised in its entirety, or not at all. The effect is that if we were to refuse to recognise the training provided on an overseas campus we would have to withdraw recognition from the programme offered by the same UK body to students in the UK. This is explicit in our guidance and medical schools have been made aware of the implications of offering a programme overseas if it does not meet the standards in *Tomorrow's Doctors*.

17. We understand that a forthcoming Section 60 Order will amend the Act so as to enable us to recognise (or withdraw recognition from) individual programmes and courses offered by a medical school. The Order will also allow us to recover the cost of quality assuring those programmes. This will give us greater flexibility, but it will not remove the fundamental statutory obligation to undertake the quality assurance of programmes wherever they are delivered.

18. Even though the 1983 Act (as amended) is couched in terms which require us to quality assure medical education and training provided overseas by recognised UK medical schools, the fact is that such initiatives were not contemplated more than a quarter of a century ago when the 1983 legislation was originally drafted. UK institutions have for many years exported their educational expertise, but it is only relatively recently that there has been an expectation that their activities overseas should be quality assured by a UK regulator.

19. Although we are bound to fulfil our statutory duty in this area, it is also right to raise questions about the fit between the requirements of the law as it now stands and the legitimate aims of UK regulation.

The purpose of UK regulation

20. It is, of course, a truism that the purpose of UK regulation is to protect, promote and maintain the health and safety of the public in the UK. The high level of international medical mobility means that we work closely with regulators in other jurisdictions to strengthen medical regulation worldwide and we share the benefits of doing so. However, that is very different from imposing the requirements of UK regulation on institutions and healthcare systems overseas (or, indeed, regulators in other jurisdictions seeking to regulate institutions and systems here). To do so by quality assuring the training delivered in other countries against UK standards is to distort the purpose of UK regulation and, arguably, to risk distorting local healthcare delivery in those countries.

21. UK medical regulation is funded through the tax-relievable annual retention fee paid by doctors registered and licensed with the GMC, the vast majority of whom are practising in the UK. It would be quite reasonable for doctors to question the use of those funds for a purpose which does not serve our overarching statutory objective of protecting the health and safety of the public in the UK. Clearly, such views would not override our legal obligations, but we must be mindful of the concerns of all our key interests.

Ethical and practical challenges

22. We also need to be alert to both the ethical and practical implications of attempting to regulate education and training delivered overseas. As Council members have previously noted, the practice of medicine is, to significant degree, culturally specific. The standards and outcomes required of UK medical graduates as set out in *Tomorrow's Doctors* reflect the fact that these doctors will be practising within the UK healthcare system. This is not the case for the vast majority of the students graduating from UK medical schools overseas (who will not, under current immigration rules, be entitled to enter the UK). They will, nevertheless, be required to meet the standards and outcomes developed for practice in the UK context.

23. This must raise questions about the appropriateness of applying those standards and outcomes in a very different context. There is, for example, a danger of distorting the way healthcare systems in other countries serve the needs of their local populations if they are subjected to a quality assurance regime designed for the needs of the UK population. Clearly, it is not for the GMC to decide what is, and what is not, suitable for the needs of healthcare systems in other countries. That is for the local jurisdiction to decide.

24. However, it is legitimate for us to be concerned about whether it will be possible for medical schools to deliver courses outside the UK which will meet the standards and outcomes of *Tomorrow's Doctors*. The evidence of our quality assurance activities so far highlights some of the challenges:

- a. Curricula taught and assessed in English in locations where patients do not necessarily speak English. This becomes a more significant issue in the clinical years of the programme.
- b. The difficulty of ensuring that students gain an equivalent understanding of the working, organisational and economic framework in which medicine is practised in the UK.
- c. The risk that students will not get a UK equivalent experience in primary care and mental health because of the different frameworks within which these may be practised overseas.
- d. Differences in ethical and legal issues between the UK and other jurisdictions.
- e. The view of disability and the rights of people with mental and physical disabilities may be very different between the UK and other jurisdictions.
- f. Differing views of social deprivation and other sociological factors, including the social and cultural environment.
- g. The need for different approaches in teaching clinical skills of examination as, depending on the student's culture, they may not be comfortable examining patients of the opposite sex.

25. These issues are significant because the education and training is intended to lead to a recognised UK medical qualification.

The risk of exporting UK regulation

26. Flowing from these practical and ethical challenges are some regulatory risks. Where the export of UK medical education leads to the award of a recognised UK primary medical qualification, graduates will be eligible for UK provisional registration and a licence to practise (although, as indicated in paragraph 22 above, not necessarily to enter the UK). However, unlike UK graduates they will have had little or no exposure to the UK healthcare system within which they might work.

27. We must also consider the risk that some UK students who were deemed unsuitable to enter medical education and training in the UK will find a convenient back door into UK medical practice through this route. As matters stand we have no direct role in the selection of students into medical education which might prevent this. There are, therefore, implications for our strategic commitment 'to register only those doctors that are properly qualified and fit to practise'.

28. The risk is small and we should not overstate it. The UK universities offering overseas training programmes will argue that they do not intend their trainees to practise in the UK and that selection processes will be the same as for UK students. These graduates will also have to satisfy any additional requirements for entry to UK Foundation Programme training arising from workforce planning and visa requirements. But the fact remains that they will be eligible for a licence to practise in the UK.

29. Assuming that a student graduates and obtains provisional registration, the route to full registration would not be straightforward. That is because they must complete a programme for provisionally registered doctors (the first year of the Foundation Programme). This would need to be under the oversight of a postgraduate deanery which, as matters stand, are the only bodies approved to provide, arrange or be responsible for such a programme. There is consequently the issue of managing trainees' expectations about their progress through the registration system.

The cost of exporting regulation

30. Undertaking the quality assurance of medical education overseas carries both real costs and opportunity costs for the GMC. For example, the cost of multi-cycle QABME visits for new programmes in the UK varies by school but is approximately £10 – £15,000 per year. This does not include the additional administrative costs of around £15,750 - £21,000 per year. While these are not factors which, in themselves, should determine our policy, we need to bear in mind that the diversion of resources into overseas activities will have an impact on the delivery of our functions elsewhere in the UK.

31. It also carries costs for the local healthcare economy if they are required to adapt local arrangements to meet UK requirements.

Promoting education, not exporting regulation

32. The arguments against UK regulatory intervention overseas are compelling. They should not, however, be seen as undermining the case for supporting educational initiatives and raising standards worldwide. UK universities and medical Royal Colleges have a track record of overseas involvement which we need to recognise as valuable to the countries concerned and to the UK.

33. Indeed, the GMC itself provides support and guidance for other regulators worldwide, particularly in jurisdictions where medical regulation is a new or developing phenomenon. Our participation in the International Association of Medical Regulatory Authorities (IAMRA) is one expression of this. We have also, for example, sent delegations to advise on the establishment of medical regulation in Albania, and have contributed to an international guide on medical regulation. We are involved in these initiatives because we consider that it helps to enhance medical regulation worldwide and, in view of the high levels of international medical mobility, enhances regulation and patient protection in the UK. Yet we do not attempt to regulate in other jurisdictions.

34. Similarly, initiatives by UK universities to export their expertise overseas should be welcomed. This can be done without institutions awarding qualifications which confer on overseas students eligibility to practise in the UK, and which therefore have implications for UK patients and UK medical regulation.

Recommendation: To acknowledge the GMC's current statutory duty to quality assure undergraduate medical education and training provided by recognised UK medical schools wherever that is delivered.

Recommendation: To endorse the principle of UK institutions working to support improvements in the standards of medical education and training worldwide.

Recommendation: To agree that it is inappropriate for the GMC to be required to undertake the quality assurance of medical education and training provided by recognised UK medical schools overseas and to seek legislative change to end this requirement.

35. It should also be noted that while the focus of this paper is on particular issues associated with the UK recognition and regulation of undergraduate medical education overseas, postgraduate education and training may also include overseas components. In due course, we will need to consider the regulatory implications of that. However, if Council endorses the proposals in this paper we would see them as applying equally to all stages of medical education.

Meeting legitimate expectations: transitional arrangements

36. As this paper has noted, there are several UK medical schools which are already putting in place arrangements to deliver their primary medical qualifications in locations outside the UK. They have pursued this course of action and committed resources, at least in part, on the basis of guidance to medical schools issued jointly by the GMC and the Medical Schools Council in 2008. Individual students will also make plans which are informed by the existing legislative and regulatory framework.

37. The recommendation that we should seek a change in the law so that the GMC is no longer required to quality assure education and training delivered outside the UK will not prevent UK institutions setting up campuses and courses overseas. It would, however, affect the recognition of that education and training in the UK.

38. If the Government is prepared to amend the Act it is likely to introduce savings provisions to protect any rights and expectations previously enjoyed by those affected. It will also want to include fair and reasonable transitional arrangements for introducing the new arrangements. We should support such arrangements.

39. It is too early to specify what the appropriate saving and transitional arrangements will need to be. As yet, no students have embarked on an overseas course which they expect to lead to a UK primary medical qualification. Nevertheless, we should make clear that we regard it as necessary that there should be saving and transitional provisions which will bring an end to our regulatory obligations overseas in an orderly, managed and equitable manner.

Recommendation: To agree in principle the need for amending legislation to include saving and transitional provisions which will end our regulatory obligations overseas in an orderly, managed and equitable manner.

Resource implications

40. Paragraph 30 outlines some of the resource implications of our involvement in the quality assurance of medical education overseas. If successfully implemented the recommendations in this paper would move us to the position where we were no longer required to undertake this activity and would therefore achieve a saving of both real and opportunity costs in the long term.

41. We anticipate that a forthcoming Section 60 Order will enable us to recover the costs of quality assuring UK undergraduate medical education provided overseas. To that extent, even if we are unable to secure the legislative changes proposed in this paper we might expect to be able to recoup our expenditure in this area. But the opportunity cost of having to undertake quality assurance overseas would remain.

Equality

42. As paragraphs 22-25 make clear, the current duty upon us to regulate UK medical education delivered overseas creates both ethical and practical challenges. The work undertaken to date indicates that one of the difficulties facing medical schools will be meeting UK requirements linked to equality and diversity because of the culturally specific nature of medical practice. This reinforces the case for uncoupling the provision of education overseas from UK regulation.