20 April 2011

Postgraduate Board

To consider

National Professional Examinations – Outcomes of the Consultation

Issue

1. The outcome of the GMC’s recent consultation on certain issues concerning national professional examinations, and discussion of the further work which is now required.

Recommendations

2.

a. To note the outcome of the consultation on the national professional examinations (paragraphs 10-18 and Annex A).

b. To agree that the Academy of Medical Royal Colleges should be invited to lead discussions with medical Royal Colleges, Postgraduate Deaneries, trainees, patients and the public and representatives of the NHS with a view to achieving agreement by 31 December 2011 in respect of the currency, timing and number of attempts at professional examinations (paragraphs 19-25).

c. To note our intention, subject to there being agreement that AoMRC should lead further discussions of this matter, to extend the current flexibility on accepting examination passes for a CCT to 31 October 2013 (paragraph 25).

Further information

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

3. The General Medical Council sets standards for postgraduate training and, among other things, approves curricula and assessment systems including examinations, assessments and tests of competence.

4. On 9 April 2010, we sent a note to our key interest groups about the legal position on the recognition of national professional examinations for the award of a Certificate of Completion of Training (CCT). The note reflected the approach previously taken by PMETB and was based on legal advice that it had received (in 2006 and 2010). We said that in order for an approved examination to be taken into account among the requirements leading to a CCT, it must be taken during a period of recognised training. This approach potentially affected doctors who had left their training programme by the time they passed the examination, doctors in service posts, and doctors who took an examination during a period of unapproved training in another country.

5. A number of trainees and medical Royal Colleges raised concerns about this approach and we were asked to review the position. We sought advice from Leading Counsel. That advice made it clear that there is flexibility in the current legislation to allow (but not require) the GMC to approve curricula and assessment systems leading to a CCT even if national professional examinations (approved by the GMC) were taken when the trainee was not within an approved training programme.

6. The legal advice and the implications for the rules governing the award of a CCT were discussed at a meeting of key interest groups on 17 June 2010. At that meeting the GMC indicated that it wished to be as flexible as possible, consistent with maintaining the integrity of the training programmes and that it was anxious to ensure that the legitimate expectations of trainees in relation to the approval of success in examinations were met.

7. Following the meeting, and further constructive discussions with key interests, the GMC decided that doctors already in, or who entered, specialty including GP training by 31 October 2011 (subsequently extended until 31 October 2012) would be able to have any valid passes in previously approved national examinations counted, even if obtained outside approved training before they enrolled for a CCT programme (core, higher or run through). We also said that we would in due course conduct a review of the standards for curricula and assessment systems, in the light of issues raised in the recent discussions including around some inconsistencies in approach across specialties in relation to aspects of the national examinations.

8. At its September 2010 meeting, the Postgraduate Board decided that, pending a full review of the standards for curricula and assessment systems in due course, we should meantime consult on some specific issues about examinations raised in the recent discussions including about currency, timing, and the number of attempts a candidate could make.
Discussion

9. The consultation was held between 17 January 2011 and 31 March 2011. A detailed analysis of the consultation is at Annex A.

Outcomes

10. There were 104 responses with 77 submissions from individuals and 27 from organisations.

11. Of the individuals who responded, 84% were doctors. Of the organisations who responded, 63% were medical Royal Colleges, Faculties and specialty societies or associations including the Academy of Medical Royal Colleges (AoMRC). We also received responses from the Conference of Postgraduate Medical Deans (COPMeD) including five individual Postgraduate Deaneries as well as a response from one NHS primary care trust and one medical school. In terms of professional bodies representing doctors, the British Medical Association (BMA), the Medical Women’s Federation and the British Geriatrics Society responded.

12. We did not receive submissions from any organisations representing patients or the public, nor any responses from the UK Departments of Health or organisations representing employers or those who contract with doctors. The one healthcare organisation that responded was a Primary Care Trust.

Currency

13. The consultation sought feedback on whether there is a potential risk if a doctor had passed an earlier version of an examination rather than the latest version. Many respondents supported a flexible approach that would allow a pass in an earlier version of an examination to be accepted, although the BMA said that currency could be an issue where the doctor had been out of practice for a significant length of time. AoMRC said that the principle of using the most up-to-date version was obviously correct but that there would be circumstances where this was not practical. COPMeD did not support the use of the most up-to-date examination because they should be linked to the curriculum, which changes at a slower rate than the day-to-day practice itself. Other assessment processes are more appropriate in these circumstances.

Timing

14. The GMC does not currently impose a time limit on the interval between passing the national professional examination and entering or re-entering training. The consultation sought views on whether the GMC should impose a maximum time limit on the validity of an examination, and suggested that seven years might be appropriate.
15. There was a fair degree of support for limiting the currency of a knowledge based examination pass, but with scope for flexibility. The BMA, for example, distinguished the position of doctors who had been out of practice, for whom there should be a limit, from doctors in practice for whom they argued a limit was unnecessary. COPMeD also supported, in theory, a limit on the currency of the examinations, but suggested this was not necessary the role of the GMC.

**Number of attempts**

16. Some medical Royal Colleges already limit the number of times a doctor may take a national professional examination, and several impose limits on the maximum interval between taking different parts of an examination. The consultation sought views on whether there should be a maximum number of attempts, and if so, whether six attempts would be appropriate.

17. Opinion was divided. The BMA argued that any limits should be imposed by the relevant medical Royal College rather than the GMC because the circumstances might well differ between specialties. AoMRC said that the international consensus is not to limit attempts although they would be happy to work with Postgraduate Deans and other key interests to try to develop a consensus on the maximum number of attempts and on the educational criteria that would have to be met if this limit was to be allowed to be exceeded. COPMeD reiterated the AoMRC position that there should not be a limit on the number attempts to pass an examination. It suggested other training processes such as remediation limits attempts naturally without introducing a potentially unfair limitation,

**Recommendation:** To note the outcome of the consultation on the national professional examinations

**Next steps**

18. The GMC has identified four key interest groups in respect of medical regulation (patients and the public, the NHS and other providers of care, doctors, and medical schools and medical Royal Colleges – to whom we would also add Postgraduate Deaneries). The consultation has not been successful in securing responses from all our key interests. In particular, despite our best efforts we have had virtually no input from patients and the public or the NHS and other providers of care.

19. In so far as there is a consistent view from respondents to the consultation, it might be summed up as indicating some support for limits around examinations, but with scope for flexibility in terms of specialty and individual circumstances.

20. The GMC’s purpose is to protect patients. We continue to believe that the current situation, in which there are unexplained differences of approach between specialties with regard to the issues on which we consulted and when some specialties allow unlimited attempts to pass important, summative examinations, does not provide an acceptable basis for us to be sure that patients are being adequately protected. For so long as that assurance is missing, we believe that there is a legitimate role for the regulator in setting a backstop in these areas. However,
any limits imposed by the regulator need to be based on evidence and command the maximum possible confidence and support of key interests.

21. Those conditions are not met at this time. It would be unfair to trainees to make decisions that limit the flexibility currently available to them without a very clear rationale and a broad measure of consensus.

22. In so far as evidence is concerned, the review of PLAB – which is about to begin – and the review of the equivalence routes to the specialist register which is already underway, may provide information and learning which is relevant and which we would want to have the opportunity to take into account. We are also in the process of commissioning some work to increase our understanding of the breadth of approaches in the various specialty assessment systems, prior to beginning a review of our standards (probably in 2013). That work on assessment might also provide important information relevant to this issue.

23. In terms of the possibility of achieving consensus, the AoMRC has kindly offered to work with Postgraduate Deans and others in relation to the number of attempts normally allowable, and AoMRC has also said that there is acceptance that a currency of five to seven years is probably about right.

24. We believe that, in that light, there is scope to reach agreement and if so, we would want to allow a chance for that to emerge before intervening to impose regulatory limits. We therefore propose that AoMRC should be invited to lead discussions on the questions of currency/timing, and number of attempts with a view to achieving a consensus that we could then endorse. If, however, no consensus could be achieved, we would be minded to impose limits on the basis of the best evidence then available. We think it reasonable that we allow until the end of 2011 for the further discussions that are necessary to take place. In the meantime, subject to the outcome of the discussion at the Postgraduate Board, we will extend the current flexibility in accepting examination passes towards a CCT from 31 October 2012 to 31 October 2013.

**Recommendation:** To agree that the Academy of Medical Royal Colleges should be invited to lead discussions with medical Royal Colleges, Postgraduate Deaneries, trainees, patients and the public and representatives of the NHS with a view to achieving agreement by 31 December 2011 in respect of the currency, timing and number of attempts at professional examinations.

**Recommendation:** To note our intention, subject to there being agreement that AoMRC should lead further discussions of this matter, to extend the current flexibility on accepting examination passes for a CCT to 31 October 2013.

**Resource implications**

25. There are no resource implications.
Equality

26. There will need to be full and open recognition of the particular needs of less than full time trainees. Trainees on maternity leave, on leave for health or disability reasons or on long research activities also need to be considered and any changes must not unfairly disadvantage doctors in these or similar circumstances.

Communications

27. We will have to develop a communication strategy to work with the AoMRC, medical Royal Colleges and Faculties as well as other relevant interests to make sure they undertake the work to rationalise currency, timing and number of attempts.

28. This paper and its annex will be published on the GMC website.