To consider

Making sure all licensed doctors have the necessary knowledge of English to practise safely in the UK

Issue

1 Amendments to our rules and regulations to strengthen the processes we have in place for ensuring that all licensed doctors have the necessary knowledge of English to practise safely in the UK.

Recommendations

2 Council is asked to:

   a Note the changes made to the draft Fitness to Practise Rules following our consultation.

   b Note the consultation report at Annex B.

   c Note the independent audit of the responses to the consultation at Annex C.

   d Agree to delegate authority to the Chair of Council to make the Regulations set out in Annexes D to G once any final drafting points have been agreed with Department of Health lawyers.
Making sure all licensed doctors have the necessary knowledge of English to practise safely in the UK

Issue

3 Currently, all international medical graduates (IMGs) must demonstrate to the GMC that they have the necessary knowledge of English before they can practise as doctors in the UK. The GMC only grants registration with a licence to practise if they can do so. However, the law currently prevents the GMC from seeking evidence about the English language skills of European doctors.2

4 Furthermore, while we currently investigate complaints about doctors’ knowledge of English language, we have identified ways in which we can strengthen our ability to deal with these concerns.

5 In February 2013, the UK Government announced plans to give the GMC new powers to ensure that all doctors working in the UK have the necessary knowledge of English to practise safely.

The Department of Health (England) and changes to the Medical Act 1983

6 The Department of Health (England) undertook a consultation on a proposed section 60 Order setting out changes to the Medical Act 1983 (the Act). The consultation ran from 7 September to 2 December 2013.3 The changes to the Act proposed by the Department cover two key areas:

- to enable us to ask European doctors for evidence of their English language skills where we have concerns about their ability to communicate effectively, before we grant a licence to practise
- to strengthen our ability to take action in relation to doctors who are already licensed where concerns are raised about their knowledge of English.

1 For the purposes of this document, an IMG is a doctor who is not a UK graduate or a European doctor.

2 In this document, the term ‘European doctor’ refers to a doctor who is:
   - a national of a relevant European state (this means a national of a member state of the European Economic Area or Switzerland), or
   - not a national of a relevant European state, but is entitled to be treated no less favourably for these purposes because he or she benefits under the Citizenship Directive from an enforceable Community right.

3 The consultation report was published on 30 January 2013 at https://www.gov.uk/government/consultations/ensuring-doctors-have-sufficient-english-language-capability
7 We worked closely with DH(E) officials and lawyers and have commented extensively on previous drafts of the Order. The Department has informed us that the changes to the Act are likely to come into force in late April 2014.

Our consultation

8 Our consultation ran from 17 September to 10 December 2013. The consultation document is at Annex A. We received 302 responses - 267 responses were from individual respondents and 35 were from organisations. The consultation report, at Annex B, sets out further information on our methodology, the breakdown of responses and our analysis. Overall, the responses to our consultation demonstrate a high level of support for our proposals.

9 We commissioned an external audit of our consultation. The audit report is at Annex C, and confirms that our consultation analysis was robust and accurate.

Licence to Practise and Revalidation Regulations 2012

10 The first part of the consultation sought views on our proposed General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations 2014. These are set out in Annex D and will allow us refuse to grant a licence to a European doctor where an applicant is unable or unwilling to demonstrate that they have the necessary knowledge of English.

11 We received overwhelming support for these proposals (between 84% and 90% agreement across the three questions), including from organisations like the BMA and the medical royal colleges. The small number of respondents who disagreed with these proposals did so mainly because they felt that assessing language skills was an employer’s responsibility, they had concerns around the evidence we currently require from IMGs or they thought that the proposals might restrict freedom of movement in the European Union. We respond to these comments in the consultation report.

12 Based on this high level of support, we do not propose to make any changes to the draft Licence to Practise and Revalidation Regulations that were the subject matter of the consultation.

Fitness to Practise Rules 2004

13 The second part of the consultation sought views on our proposed Fitness to Practise (Amendment) Rules 2014 that will enable us to take action in relation to doctors who are already on our register where concerns are raised about their language skills. We also sought views on the General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) (Amendment) Regulations 2014 and the General Medical Council (Restoration following Administrative Erasure) (Amendment) Regulations 2014. These are set out in Annexes D to G.
In general, there was a very high level of support for our proposals for dealing with fitness to practise concerns arising from a doctor’s lack of knowledge of English. As a result, we intend to proceed with the necessary rule changes to enable us to direct doctors to undergo an English language assessment where there are concerns about their fitness to practise and to seek to suspend a doctor indefinitely if they repeatedly fail to meet the necessary level of competency.

There was a broad consensus that training and guidance for decision makers is crucial to ensure referrals for language assessments are managed fairly, proportionately and based on appropriate evidence. Many respondents also recognised that we must provide clear information for doctors to ensure they understand what is expected of them. Some patient groups commented on the need for adequate public protection during our investigation and we will be amending our guidance for our decision makers to ensure that they consider reference to an Interim Orders Panel where a doctor’s lack of English language skills is putting patients at risk.

Opinion was divided over plans to charge doctors for language assessments undertaken as a requirement of a fitness to practise investigation. The Professional Standards Authority and the BMA were among those who raised comments about consistency with our approach in performance and health cases where the GMC meets the cost of any health or performance assessment that a doctor is required to take. Others mentioned the possibility of a doctor incurring costs for such an assessment where concerns about their language skills might prove to be unfounded.

We believe that some of these concerns are legitimate and we have decided to amend our proposals to provide that the GMC meets the cost of language assessments required as part of any fitness to practise investigation to ensure fairness in our procedures. In view of the current volume of language cases, this is not expected to have a significant impact on budget and the cost of undertaking such a test (approximately £120) is relatively insignificant compared to the cost of a performance or health assessment.

Equality analysis

We undertook a detailed Equality Analysis, which we are currently updating following the consultation. We are aware of a perception among some IMG doctors that the current position of testing IMGs and not European doctors is unfair. Our proposal will bring greater consistency between European doctors and their IMG counterparts. 90.7% of respondents agreed that it is fair and proportionate to require the same evidence of English language proficiency from European doctors as IMGs.
Approval of our rules and regulations

19 The legislation gives Council the power to make amended rules and regulations subject to agreement by the Privy Council. Council can delegate this power to the Chair of Council when it decides it is appropriate to do so. We believe that the draft rules and regulations at annexes D to G each represents a version that is very close to being finalised. However, there may be some final tweaks by lawyers in preparation for sign off by Privy Council.

20 In the circumstances, we are asking Council to agree for the Chair of Council to make these rules and regulations once the drafts have been finalised. However, if anything more than minor drafting amendments are proposed to any of the rules or regulations, we will return to Council and ask for agreement to those changes.
Supporting information

How this issue relates to the corporate strategy and business plan

22 In our 2014-17 Corporate Strategy, strategic aim 3 is to improve the level of engagement and efficiency in the handling of complaints and concerns about patient safety. The changes we have proposed will strengthen our ability to deal with complaints and concerns about a doctor’s knowledge of English.

23 Strategic aim 5 is to work better together to improve our overall effectiveness, our responsiveness and the delivery of our regulatory functions. A range of teams across the GMC (in particular Registration and Revalidation, Fitness to Practise and Europe and International) have worked together to develop these proposals. The current limitations around testing language proficiency (both prior to registration and licensing and once a concern is raised through our fitness to practise processes) present a patient safety risk that warrants addressing. This will contribute to public assurance and enhance the robustness of our regulatory framework.

Other relevant background information

24 In July 2013 the Strategy and Policy Board endorsed our approach to ensuring that all licensed doctors have the necessary knowledge of English, agreed the draft rules and regulations for the purposes of consultation, and agreed our approach to our public consultation. We shared the consultation document with Council members prior to its launch.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

25 We undertook a three-month public consultation in parallel with the DH’s consultation on the section 60 Order. The report at Annex C summarises the responses to the consultation. We also attended a number of meetings to discuss the proposals, such as the GMC’s BME Doctors Forum and the BMA’s International Committee. We worked closely with DH in preparing the legislation.

26 We have a range of internal project boards to represent views from across the organisation and ensure that the right expertise is available to the project. This includes Communications, Legal and Europe and International.

27 Prior to implementation, we will update our online information as well as update a range of guidance across our registration and fitness to practise functions.

How the issues differ across the four UK countries

28 Both our Fitness to Practise and Registration processes apply consistently across the four countries. However, it is worth noting that the Responsible Officer
Regulations specifically require ROs in England to ensure that doctors have ‘sufficient knowledge of the English language necessary for the work to be performed in a safe and competent manner’. Local arrangements are in place in the other countries.

**What equality and diversity considerations relate to this issue**

29 We have undertaken a full Equality Analysis, which we are currently updating following the consultation. We published a summary of the analysis with the consultation documents. We are developing guidance to ensure our proposals are applied fairly and proportionately.

If you have any questions about this paper please contact: Jon Billings, Assistant Director - Registration and Revalidation, jbillings@gmc-uk.org, 020 7189 5434.
Consultation document: Making sure all licensed doctors have the necessary knowledge of English to practise safely in the UK

1 This consultation document sets out our proposals for ensuring that all doctors have the necessary knowledge of English. We consulted on these proposals from 17 September to 10 December 2013.
Making sure all licensed doctors have the necessary knowledge of English to practise safely in the UK: a consultation
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20 Annex
21 Annex A: current evidence requirements for international medical graduates
We are consulting on plans to further strengthen the safeguards that are already in place to make sure all licensed doctors have the necessary knowledge of English to practise safely in the UK.

The first part of this consultation seeks your views on changes to our regulations that will let us ask for evidence of a European doctor’s English language skills before we grant a licence to practise in the UK. More information is set out in the section on demonstrating the necessary knowledge of English (pages 8–13).

We are also seeking views on further changes to our regulations that will help us to take action in relation to doctors who are already licensed where concerns are raised about their language skills. More information is set out in the section on changes to the Fitness to Practise Rules 2004 (pages 14–19).

The consultation runs from 17 September to 10 December 2013. We expect to publish the outcome of the consultation early in 2014.

Annexes B, C, D and E of this consultation document can be found online at www.gmc-uk.org/doctors/consultations/english.asp.

* In this document, the term ‘European doctor’ refers to a doctor who is:
  
  • a national of a relevant European state (this means a national of a member state of the European Economic Area or Switzerland), or
  
  • not a national of a relevant European state, but is entitled to be treated no less favourably for these purposes because he or she benefits under the Citizenship Directive from an enforceable Community right.
Why should the consultation matter to you?

- **All registered doctors** – this consultation describes how we will investigate allegations that a doctor does not have the necessary knowledge of English to practise safely. It also explains the actions we may take in such cases to protect patients.

- **European doctors considering applying for a licence to practise in the UK** – this consultation sets out how we will make sure that all such doctors have the English language skills they need.

- **Healthcare organisations** – responsible officers, employers and contractors of doctors’ services are responsible for making sure that the doctors they employ or appoint have all the necessary skills to practise safely. They will need to understand how the GMC intends to assess the English language skills of European doctors before a licence is granted and how that differs from their own responsibilities for making sure that a doctor has the necessary skills to do a particular role. Healthcare organisations will also have an interest in how we might investigate any concerns they raise about a doctor’s knowledge of English.

- **Patients and the public** – this consultation explains how we will protect patients by making sure all licensed doctors have the necessary knowledge of English to practise safely in the UK.

How to respond

You can respond to the consultation in three ways:

- online through our e-consult website at https://gmc.e-consultation.net

- email your response to englishlanguage@gmc-uk.org

- post your response to English language consultation, General Medical Council, 350 Euston Road, London NW1 3JN.

If you have any questions about the consultation, or need the information in an alternative format, email englishlanguage@gmc-uk.org or call us on 0161 923 6602.

The Department of Health is currently consulting on amendments to the **Medical Act 1983** (the Act) to make sure that we have the necessary legal powers to implement these changes. You can view and respond to the Department of Health’s consultation on its website at [www.gov.uk/government/consultations/ensuring-doctors-have-sufficient-english-language-capability](http://www.gov.uk/government/consultations/ensuring-doctors-have-sufficient-english-language-capability).
Background
**Current position**

1. All international medical graduates (IMGs)* must demonstrate that they have the necessary knowledge of English before they can practise as doctors in the UK. We only grant registration with a licence to practise if they can do so.

2. Most IMGs demonstrate that they have the necessary language skills by passing the academic version of the International English Language Testing System (IELTS) test at the required level. Alternatively, we also accept a limited range of recent evidence of English language skills, such as:
   - documentary evidence of a primary medical qualification taught and examined solely in English
   - continuous practice in a country where English is the first and native language.†

3. However, the law currently prevents us from seeking evidence about the English language skills of European doctors as a condition of registration. If these doctors have a recognised medical qualification from a medical school based in a member state of the European Economic Area or Switzerland, we are required by law to grant registration and a licence to practise without any further assessment or testing. This means that we are currently prohibited from asking these doctors to provide any evidence of their language skills.

**International English Language Testing System (IELTS)**

4. IELTS is currently run jointly by the British Council, IDP:IELTS Australia and Cambridge English Language Assessment‡ and is the primary means by which IMGs demonstrate their proficiency in English.

5. We currently require IMGs to achieve a minimum score of 7.0 (out of 9.0) across all aspects of the academic version of the test. The cost of this assessment is borne by the doctor. The current fee in the UK is £135 and the test takes place in centres in the UK and all over the world.

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* For the purposes of this document, an IMG is a doctor who is not a UK graduate or a European Doctor.
† Please refer to Annex A for detail about the type of evidence we require from IMGs, as well as how recent the evidence must be.
‡ Further information about IELTS and these organisations can be found at www.ielts.org/about_us.aspx.
Identifying children and young people in need

Under Directive 2005/36/EC, European doctors with a relevant qualification are entitled to have their qualifications recognised in the UK. They have an automatic entitlement to GMC registration if there are otherwise no concerns about their fitness to practise.

European doctors who qualified outside of Europe, or who have a European qualification that is not listed in the Directive, do not have an automatic entitlement to registration with a licence.

At present, the effect of registration is that the doctor also receives a licence to practise. However, the law currently prevents us from requesting evidence of the English language capability of any European doctor as a condition of their registration with a licence.

Certain functions are by law restricted to licensed doctors, such as treating patients, prescribing medicines and signing death certificates. Although registration shows that a doctor’s qualification has been recognised by the regulator and that the doctor is in good standing with us, it does not confer any of the powers and privileges associated with the licence to practise.

The UK Government announcement and Department of Health consultation

In February 2013, the UK Government announced plans to give us new powers to ensure that all doctors working in the UK have the necessary knowledge of English to practise safely. The Department of Health is currently consulting on changes to the Act to:

- enable us to ask European doctors for evidence of their English language skills where we have concerns about their ability to communicate effectively, before we grant a licence to practise
- strengthen our ability to take action in relation to doctors who are already licensed where concerns are raised about their language skills.

You can view and respond to the Department of Health’s consultation on its website at www.gov.uk/government/consultations/ensuring-doctors-have-sufficient-english-language-capability.

This consultation is about how we will implement these new powers, including the changes required to our rules and regulations.

What this change means

Under Directive 2005/36/EC, European doctors with a relevant qualification are entitled to have their qualifications recognised in the UK. They have an automatic entitlement to GMC registration if there are otherwise no concerns about their fitness to practise.

European doctors who qualified outside of Europe, or who have a European qualification that is not listed in the Directive, do not have an automatic entitlement to registration with a licence.

At present, the effect of registration is that the doctor also receives a licence to practise. However, the law currently prevents us from requesting evidence of the English language capability of any European doctor as a condition of their registration with a licence.

Certain functions are by law restricted to licensed doctors, such as treating patients, prescribing medicines and signing death certificates. Although registration shows that a doctor’s qualification has been recognised by the regulator and that the doctor is in good standing with us, it does not confer any of the powers and privileges associated with the licence to practise.
13 The proposed change to the Act will allow us to seek evidence and confirmation of a European doctor’s ability to communicate in English, if concerns about their language skills emerge during the registration process. While we will continue to recognise their qualifications through granting registration in the usual way, we are proposing that we will refuse to grant a licence to practise in circumstances where the doctor is unable to demonstrate that he or she has the necessary knowledge of English.

16 In April 2013 these responsibilities were made explicit for responsible officers based in England.† Responsible officers in England now need to make sure that doctors ‘have sufficient knowledge of English language necessary for the work to be performed in a safe and competent manner’.† Local arrangements also apply in Northern Ireland, Scotland and Wales.

17 These responsibilities will continue to exist in future, but will be strengthened by our ability to request evidence of English language skills from European doctors when concerns arise during our registration process.

**Current responsibilities of healthcare organisations and responsible officers**

14 Healthcare organisations have always had responsibilities for making sure that the doctors they recruit or appoint have the necessary skills to undertake a particular role and this includes language skills.

15 Therefore, organisations that employ or contract with doctors should already have systems in place for pre-employment checking, and these should include assessing language skills if necessary.

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* Responsible officers are senior doctors appointed by hospitals or clinics to oversee the fitness to practise of their doctors.
† The Medical Profession (Responsible Officers) (Amendment) Regulations 2013, regulation 4(2)(a)
Demonstrating the necessary knowledge of English
We currently check the language skills of IMGs before granting them registration with a licence. If they cannot demonstrate that they are proficient in English to the required level then they are not eligible for registration.

The proposed amendments to The General Medical Council (Licence to Practise and Revalidation) Regulations 2012 mean that when we are concerned that a European doctor may not have the necessary knowledge of English to practise safely, we can ask for evidence of their language skills or request that the applicant undergo an assessment to evaluate their English language proficiency before we grant a licence to practise.

The proposed amendments to the 2012 regulations are at Annex B. There are a number of key principles underlying these regulations and how we intend to implement them:

- compliance with European Union (EU) law and the EU code of conduct
- identification of concerns based on objective rather than subjective evidence
- evidence requirements that are fair and transparent and mirror our existing requirements for international medical graduates.

In the following paragraphs we describe the impact that the amendments to the regulations will have and how they will be applied and we invite your comments on some specific points.

Who the changes will affect

The purpose of the changes is to make sure that all doctors have the necessary knowledge of English before we grant a licence to practise. Although the changes will apply to all doctors, they will, in practice, only affect European doctors as IMGs are already subject to an assessment process and UK graduates will automatically satisfy the requirements as their primary medical qualification is taught and examined solely in English.

These amendments will affect any European doctor making:

- a first-time application for registration with a licence
- any first-time application for a licence where the applicant already holds registration but has never held a licence before*
- an application for restoration to the register with a licence to practise where the applicant has never previously held a licence.

This will not affect applications for restoration of a licence made by doctors who have previously held a licence.

* For example, doctors who opted to take registration only in November 2009 and therefore have never held a licence to practise.
Regulation 3 – grant or refusal of a licence

25 As part of their application for registration with a licence to practise, European doctors currently provide a range of supporting information, including:

- details of their qualifications
- details of each medical regulatory authority they have been registered or licensed with in the previous five years
- details of all of their work experience from the previous five years, both medical and non-medical.

26 From this information, we will identify whether we have any concerns about the doctor’s English language skills.

27 Where there are no concerns because, for example, the doctor has a primary medical qualification awarded by a medical school where students are taught and examined in English, we will automatically grant registration with a licence to practise.

28 Where the information does raise concerns about an applicant’s English language skills, we will automatically grant registration, but ask the doctor to provide us with evidence to demonstrate that they have the necessary knowledge of English language before we grant a licence to practise. The type of evidence we request in these circumstances will mirror what we require of IMGs and will broadly include:

- achieving the required scores in the IELTS test
- documentary evidence of a primary medical qualification taught and examined solely in English, or
- continuous practice in a country where English is the first and native language.*

29 Where evidence cannot be provided or is insufficient, then we may request the applicant to take the IELTS test at their own cost.

Question 1
Do you think it is fair and proportionate to require the same evidence of English language proficiency from European doctors as IMGs?

* Please refer to Annex A for further detail about the type of evidence we require from IMGs, as well as how recent the evidence must be.
30 An applicant who is granted registration without a licence will have part of their registration fee refunded. They will be able to make a new application for a licence once they have evidence to demonstrate their knowledge of English.

31 The applicant can appeal any refusal to grant a licence to a GMC registration appeals panel and subsequently to a county court.*

32 This process will be streamlined to ensure that it is as efficient and effective as possible for both the doctor and ourselves. Applicants will be made aware before they make their initial application, of the information that they need to provide to satisfy the licensing requirements.

33 Figure 1, on page 12, outlines the process we expect applications to follow.

**Question 2**

Do you agree that we should not grant a licence to practise to a European doctor when they have been unable or unwilling to show they have the necessary knowledge of English to practise safely in the UK?

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* In Scotland, a subsequent appeal is to the sheriff.
European doctor sets up a GMC Online account and submits an application for registration with a licence

Submitted application received by GMC and assessed

Is there a concern around the doctor’s English language capability?

Yes

Doctor asked to provide:
- documents for registration (as per current application process)
- evidence of their English language capability

No

Doctor asked to provide documents for registration (as per current application process)

Doctor provides requested documents that meet GMC requirements

Doctor is approved for registration with a licence subject to an ID check. Doctor is invited to an ID check

Doctor attends ID check and is granted registration with a licence

Doctor provides requested documents and English language capability evidence that meets GMC requirements

Doctor is approved for registration with a licence subject to an ID check. Doctor is invited to an ID check

Doctor attends ID check and is granted registration with a licence

Doctor only provides requested documents for registration that meets GMC requirements

Doctor is approved for registration without a licence subject to an ID check. Doctor is invited to an ID check*

Doctor attends ID check and is granted registration without a licence†

Doctor has evidence of their English language capability?

Yes

Doctor provides requested documents and English language capability evidence that meets GMC requirements

Doctor is approved for registration with a licence subject to an ID check. Doctor is invited to an ID check

Doctor attends ID check and is granted registration with a licence

No

Doctor asks to provide documents for registration (as per current application process)

Doctor provides requested documents that meet GMC requirements

Doctor is approved for registration with a licence subject to an ID check. Doctor is invited to an ID check

Doctor attends ID check and is granted registration with a licence

Doctor only provides requested documents for registration that meets GMC requirements

Doctor is approved for registration without a licence subject to an ID check. Doctor is invited to an ID check*

Doctor attends ID check and is granted registration without a licence†

* Up until the ID check, the doctor is able to provide evidence of their English language capability.

† Doctor can apply for a licence at a later date, but will be required to provide evidence of their English language capability.
Regulation 6 – revalidation

34 We receive a revalidation recommendation about each doctor from their responsible officer once every five years. This confirms to us that the doctor is participating in the processes that support revalidation and that there are no unaddressed concerns about the doctor’s fitness to practise.

35 As this recommendation already confirms that the responsible officer is not aware of any unaddressed concerns about the doctor’s fitness to practise, we do not intend to add any additional requirements focusing specifically on a doctor’s language skills.

36 However, the amendment to regulation 6 clarifies that we can require a doctor with no prescribed connection* or suitable person† to undertake an assessment of their knowledge of English as part of the revalidation process if we believe it appropriate to do so. This is because we will not receive additional assurance through a recommendation from a responsible officer or suitable person.

Question 3
Do you agree that it is fair and proportionate to be able to ask doctors who have no responsible officer or suitable person to demonstrate they have the necessary knowledge of English where we have a concern, as part of their revalidation?

* Most licensed doctors have a connection with one organisation that will provide them with a regular appraisal and help them with revalidation. This organisation is called their ‘designated body’. It will be the responsible officer of this designated body that will make a recommendation to us about their revalidation. A small minority of doctors will not have a responsible officer due to the nature of their practice and where they work.

† In certain circumstances we will accept revalidation recommendations from other suitable persons if we are satisfied they are performing roles equivalent to those of appointed responsible officers. We can recognise suitable persons under the General Medical Council (Licence to Practise and Revalidation) Regulations 2012, regulation 6(6) and (7).
Changes to Fitness to Practise Rules 2004
Introduction

37 This section of the consultation deals with how we will investigate concerns or complaints about a registered doctor’s English language skills.

38 As discussed in previous sections, in future, European doctors may need to demonstrate they have the necessary knowledge of English to provide safe care to patients before they are granted a licence to practise medicine in the UK.

39 Our core guidance for doctors, *Good medical practice* (2013), says doctors must provide information to patients in a way they can understand* and work collaboratively with colleagues.†

40 When we receive a serious complaint about a doctor’s ability to communicate with patients and other health professionals, we undertake an investigation to decide whether it is necessary to take action to protect the public. We are proposing to make some changes to how we do this, where communication problems seem to arise from a doctor’s inadequate knowledge of English.

What changes are we proposing?

41 The three main changes to our fitness to practise process are:

a Creating a new category by which doctor’s fitness to practise may be found impaired – ‘not having the necessary knowledge of English’.

b Introducing a new power for the registrar and fitness to practise panels to direct a doctor to undergo a language assessment where there are serious concerns about their ability to communicate in English.

c Allowing fitness to practise panels to ‘indefinitely suspend’ doctors who fail over time to develop sufficient English language skills to treat patients safely.

42 A detailed discussion about each of these changes is provided below at paragraphs 50 to 64.

43 To make these changes, the Department of Health will need to amend the Act. We will need to amend the *Fitness to Practise Rules 2004*. Our proposed amendments are at annex C, which can be found online at [www.gmc-uk.org/doctors/consultations/english.asp](http://www.gmc-uk.org/doctors/consultations/english.asp).

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Who will the changes apply to?

44 The changes apply to all doctors, regardless of nationality, place of qualification, or whether they were required to provide evidence of English skills when they applied for registration or a licence.

45 The changes are most likely to affect doctors whose first language is not English.

Introducing a new category of impaired fitness to practise

46 Doctors on the medical register are expected to follow our guidance, keep their professional skills and knowledge up to date and communicate effectively with patients and other health professionals.

47 Where a doctor fails to do this, their fitness to practise medicine may be found to be impaired for five reasons: deficient performance, misconduct, adverse physical or mental health, a conviction or caution, or a determination by another regulatory body. These categories are set out in legislation, under section 35C(2) of the Act. Historically, serious complaints about a doctor’s communication skills, including knowledge of English, have been categorised as potentially deficient performance.

48 In future, the Department of Health’s consultation proposes that if a doctor’s inability to speak, write, read or comprehend English means they are unable to treat patients safely, the GMC should be able to clearly state this as the reason their fitness to practise is impaired. This involves creating a new category of impairment in the Act ‘by reason of not having the necessary knowledge of English.’ Details of the Department’s consultation are on its website at www.gov.uk/government/consultations/ensuring-doctors-have-sufficient-english-language-capability.

Asking doctors to undergo a language assessment when we investigate concerns about their communication skills

49 When we receive a complaint about a doctor we gather a range of information to see what evidence exists in support of the concerns raised. This helps us to make fair and properly-reasoned decisions about whether it is necessary to take action to protect patients and maintain confidence in the profession. If a case is referred to a hearing, a fitness to practise panel convened by the Medical Practitioners Tribunal Service will look at the evidence and decide if the doctor is impaired.

50 As part of the information gathering process, we think the registrar and panels should have a new power to require doctors to undergo a language assessment if evidence of their language skills is needed for us to make a decision about their fitness to practise medicine in the UK. This is consistent with our approach in performance and health cases where we ask doctors to undergo an assessment of their performance or health, as appropriate.

51 The language assessment will consider a doctor’s ability to speak, read, write and understand English and is likely to be the same test (IELTS) required of doctors when they apply for registration and/or a licence. We only envisage doctors being asked to undertake a language assessment as part of our fitness to practise process if there is a specific concern that their ability to provide safe care to patients is impaired due to insufficient knowledge of English. Doctors will be responsible for the cost of a language assessment directed by the registrar as a result of fitness to practise concerns.
To make sure that doctors are treated fairly, we will also issue guidance for decision makers to ensure that a doctor is required to undergo an assessment of their knowledge of English only where additional evidence is reasonably needed. For example, if a doctor has recently undertaken an assessment, we are likely to consider it unnecessary to ask them to do so again.

Question 4
Do you agree that if there is a serious concern about a registered doctor’s knowledge of English, we should have the power to require a doctor to undergo a language assessment?

Question 5
Do you agree doctors should pay the cost of a language assessment where there is a relevant fitness to practise concern?

Dealing with doctors who fail to undergo a language assessment during an investigation

If a doctor fails to undertake a language assessment when requested to do so where there is a concern about their fitness to practise, we may be unable to gather the information we need to decide if they are safe to treat patients. In such cases, after reasonable steps to encourage the doctor to comply, the matter will be referred to a fitness to practise panel. Where the matter is heard by a panel on non-compliance grounds, they will consider whether it is necessary to take action on the doctor’s registration to mitigate the risk to the public. This approach is consistent with our approach in health and performance cases where doctors fail to undergo an assessment during our investigation.

To ensure fairness to doctors, we will allow a suitable period of time to comply with a direction to undergo a language assessment. We suggest 90 days is sufficient time for a doctor to prepare and attend a test centre. This is consistent with the time provided for IMGs applying to join the register to provide any additional evidence required. Any doctor who states that they do not intend to comply, or who fails to comply within this period without good reason may be referred to a fitness to practise panel.

Question 6
Do you agree that 90 days is a reasonable time period for doctors to comply with a direction to undertake a language assessment?
Indefinite suspension of doctors who do not have sufficient English language skills to treat patients safely

55 Where concerns are raised about a registered doctor’s knowledge of English, we will encourage them to take steps to improve their language skills voluntarily. However, if a doctor’s language does not improve sufficiently or they are unwilling to agree the necessary action, the case may be referred to a fitness to practise panel to consider if action is necessary to protect the public.

56 The panel will look at all of the relevant evidence, including any language assessments which the doctor has undertaken, to decide if the doctor’s fitness to practise medicine is impaired. If they find the doctor lacks sufficient knowledge of English to treat patients in the UK safely, a range of options are available to them. For example, the panel may agree or impose limits on a doctor’s registration until they have adequately improved their knowledge of English. Alternatively, they may feel it is necessary to suspend the doctor’s right to practise medicine in the UK.

57 The time it takes people to learn English may vary widely. There may also be some doctors who refuse to take appropriate steps to improve their skills. At present, the maximum period of suspension is 12 months, although this may be extended following a review by a fitness to practise panel. However, where a doctor’s language skills do not improve over time, we propose that panels have a power to suspend the doctor’s registration indefinitely. This approach, which reflects our current powers in cases in which a doctor is impaired solely as a result of health issues, will remove the need for repeated reviews to be carried out where no progress has been made. A doctor will be able to request a review when, and if, they have acquired the necessary knowledge of English.

58 In such cases, indefinite suspension would be the most serious outcome available to us in dealing with concerns about a doctor which relate solely to their knowledge of English. European doctors are legally entitled to have their qualifications recognised in the UK and it would be disproportionate to remove their name from the medical register due to a lack of proficiency in a particular language. In order to ensure consistency and equity, we are proposing that indefinite suspension should be the more serious outcome for any doctor whose fitness to practise is found to be impaired solely on the basis that they do not have the necessary knowledge of English.

59 Implementing this proposal will involve amending the Indicative Sanctions Guidance for panellists. This guidance explains the options available to panellists when deciding the outcome of a case. A copy of this can be accessed from the Medical Practitioners Tribunal Service website, www.mpts-uk.org.

Question 7
Do you agree that we should be able to indefinitely suspend doctors who fail over time to acquire the necessary knowledge of English to safely treat patients in the UK?
Restoration of a doctor’s name to the medical register following fitness to practise concerns in language cases

60 As discussed above, doctors will not be erased from the register solely due to insufficient knowledge of English. However, where a doctor has been erased from the register and applies for their name to be restored, if there is a concern we will be able to direct them to undergo a language assessment before being restored.

61 In addition, doctors under investigation because of concerns that their fitness to practise may be impaired due to insufficient language skills will remain eligible to apply for voluntary erasure to remove their name from the register. Doctors may also be administratively erased for non-payment of fees or for failure to maintain an effective registered address.

62 In such cases, where a doctor later applies for restoration to the register with a licence they may be asked to undergo a language assessment to make sure they are safe to treat patients.

63 These changes expand our current powers to investigate a doctor’s fitness to practise in these circumstances, to allow us to direct a doctor to undergo a language assessment where there are outstanding concerns about their language skills.

64 The amendments to the procedures relating to restoration following voluntary or administrative erasure in the General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) (Amendment) Regulations 2014 and the General Medical Council (Restoration following Administrative Erasure) (Amendment) Regulations 2014 are at annex D and E, which can be found online at www.gmc-uk.org/doctors/consultations/english.asp.

Question 8
Do you agree that we should be able to ask doctors to undergo a language assessment when they apply to be restored to the register if there is a concern about their language skills?
Annex A: current evidence requirements for international medical graduates

1 Required scores in the academic version of the IELTS test
   - Overall band score of 7.0, including a 7.0 in all of the elements.
   - The IELTS scores must be valid on the date on which the application is approved.

2 Primary medical qualification taught and examined solely in English
   - The applicant sat the last exam for their primary medical qualification during the 12 months before applying for registration.
   - The applicant holds a primary medical qualification which was taught and examined solely in English.

   Information to be provided
   - A statement that the applicant has not taken the IELTS test before.
   - An original letter or certificate from the institution where applicant qualified confirming:
     a that all of the course, including clinical activities, was taught and examined solely in English
     b that at least 75% of any clinical interaction, including personal contact with patients, their families and other healthcare professionals, which took place as part of the course of study, was conducted in English
     c the date on which the applicant passed their final examination.

3 Passed language test for registration in a country where the first and native language is English and has practised there continuously for the last two years
   - The applicant sat the last exam for their primary medical qualification more than 12 months before applying for registration.
   - The applicant has been working continuously for the past two years in a country where the first and native language is English.
   - The applicant is moving to the UK from an English speaking country where they took an English exam to obtain registration with the medical regulatory authority in that country.

   Information to be provided
   - A statement that applicant has not taken the IELTS test before.
   - The original English Language test certificate applicant used to gain registration or a licence in that country (we will contact the medical regulatory authority to find out what they use and their requirements).
   - Original references from applicant’s employers for the last two years, outlining their English language capability.
4 Applicant has practised continuously in a country where English is the first and native language for the past two years

- Applicant sat the last exam for their primary medical qualification more than twelve months before applying for registration.
- Applicant has been working continuously for the past two years in a country where the first and native language is English.
- Applicant holds a primary medical qualification which was taught and examined solely in English.

Information to be provided

- A statement that applicant has not taken the IELTS test before.
- Original references from all employers for the last two years, outlining the applicant’s English language capability. English language reference form to be used.
- An original letter or certificate from the institution where the applicant qualified, confirming:
  a that all of the course, including clinical activities, were taught and examined solely in English.
  b that at least 75% of any clinical interaction, including personal contact with patients, their families and other healthcare professionals, which took place as part of the course of study, was conducted in English.
  c the date on which the applicant passed their final examination.
Consultation report: Making sure all licensed doctors have the necessary knowledge of English to practise safely in the UK
Introduction

From 17 September to 10 December 2013 we consulted on proposals to further strengthen the safeguards that are already in place to make sure all licensed doctors have the necessary knowledge of English to practise safely in the UK.

The focus of the consultation was on changes we are proposing to make to some of our rules and regulations. We are required by the Medical Act 1983 (the Act) to consult prior to making or amending rules and regulations.

This document sets out a summary of the responses to our consultation.

Background

Currently, all international medical graduates (IMGs)\(^1\) must demonstrate that they have the necessary knowledge of English before they can practise as doctors in the UK. We only grant registration with a licence to practise if they can do so. However, as it stands, the law prevents us from seeking evidence about the English language skills of European doctors.\(^2\)

In February 2013, the UK Government announced plans to give us new powers to ensure that all doctors working in the UK have the necessary knowledge of English to practise safely. The Department of Health (England) undertook a consultation on proposed changes to the Act from 17 September to 2 December 2013. Changes to the Act proposed by the Department cover two key areas:

- to enable us to ask European doctors for evidence of their English language skills before we grant a licence to practise, where we have concerns about their ability to communicate effectively
- to strengthen our ability to take action in relation to doctors who are already licensed where concerns are raised about their language skills.

The response to the Department’s consultation was generally positive.\(^3\)

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\(^1\) For the purposes of this document, an IMG is a doctor who is not a UK graduate or a European Doctor.

\(^2\) In this document, the term ‘European doctor’ refers to a doctor who is:
- a national of a relevant European state (this means a national of a member state of the European Economic Area or Switzerland), or
- not a national of a relevant European state, but is entitled to be treated no less favourably for these purposes because he or she benefits under the Citizenship Directive from an enforceable Community right.

\(^3\) The Department’s consultation report was published on 30 January 2014 at https://www.gov.uk/government/consultations/ensuring-doctors-have-sufficient-english-language-capability
Our consultation

The first part of the consultation sought views on changes to our General Medical Council (Licence to Practise and Revalidation) Regulations 2012. These changes will let us ask for evidence of a European doctor’s English language skills before we grant a licence to practise in the UK.

The second part of the consultation sought views on changes to our Fitness to Practise Rules 2004 that will help us to take action in relation to doctors who are already licensed where concerns are raised about their language skills. We also sought views on the General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) (Amendment) Regulations 2014 and the General Medical Council (Restoration following Administrative Erasure) (Amendment) Regulations 2014.

The consultation document included a range of annexes setting out the guidance we currently provide to IMGs on the information we are likely to accept as evidence that they have the necessary knowledge of English, and a draft of the proposed amendments to the rules and regulations.

We also published a summary of our equality analysis online to provide further detail to those responding to the consultation. The full equality analysis was available on request.

Our approach

We asked eight questions about the proposed changes to our rules and regulations. Respondents were asked whether they agreed or disagreed with each question, and had the option of stating that they were not sure. Respondents were then asked to provide any additional comments, especially if they answered no or not sure. Annex A sets out the eight questions we asked, the breakdown of responses and a summary of the free-text responses.

Respondents were able to reply to our consultation online using our e-consult website, by email or in writing. We provided a consultation response form for those who preferred to reply by email or writing. We also published a Welsh language version of both the consultation document and response form.
We used a range of methods to publicise the consultation:
- it was prominent on our website
- we supported the consultation with an online GMC News article which is emailed to all doctors who were signed up to receive GMC News to invite their response (over 10,000 opened the webpage)
- we directly emailed over 400 relevant organisations, including charities, organisations representing doctors, medical defence unions, regulators, European medical organisations, EU institutions and stakeholders from the four UK countries to notify them of its launch and to invite responses.

During the course of the consultation we attended some events to provide information about our consultation and to invite responses. A summary of the themes that arose from attendees is set out in annex B of this report.

**Breakdown of responses**

We received a total of 302 responses to our consultation. Table 1 shows the breakdown of responses according to source. Most respondents responded by completing our e-consult survey. However some preferred to complete offline responses – completing a response form which we uploaded into the e-consult site. We also received some broader comments on the consultation by email. These comments were included in the free-text analysis, but not in the statistical analysis, as we could not clearly attribute a ‘Yes’, ‘No’ or ‘Not Sure’ response.

**Table 1**

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-consult site</td>
<td>232</td>
</tr>
<tr>
<td>Offline response</td>
<td>37</td>
</tr>
<tr>
<td>Emails</td>
<td>33</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>302</strong></td>
</tr>
</tbody>
</table>

Table 2 below provides a breakdown of the types of respondents. We received 267 responses from individuals (the overwhelming majority from doctors) and 35 responses on behalf of organisations. We grouped all medical royal colleges, faculties and the Academy into one category irrespective of their self-selected category as we felt this provided a clearer picture of the types of organisations that responded to the consultation.

Annex D provides a list of organisations that responded to our consultation.
Table 2

<table>
<thead>
<tr>
<th><strong>Organisations</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy, medical royal college or faculty</td>
<td>8</td>
</tr>
<tr>
<td>Body representing doctors</td>
<td>6</td>
</tr>
<tr>
<td>NHS/HSC organisation</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>Postgraduate medical institution</td>
<td>3</td>
</tr>
<tr>
<td>Independent healthcare provider</td>
<td>2</td>
</tr>
<tr>
<td>Regulatory body</td>
<td>2</td>
</tr>
<tr>
<td>Body representing patients or public</td>
<td>1</td>
</tr>
<tr>
<td>Medical School (undergraduate)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total organisations</strong></td>
<td>35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Individuals</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>242</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
</tr>
<tr>
<td>Medical manager</td>
<td>7</td>
</tr>
<tr>
<td>Member of the public</td>
<td>7</td>
</tr>
<tr>
<td>Information not available</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total individuals</strong></td>
<td>267</td>
</tr>
<tr>
<td><strong>Overall total</strong></td>
<td>302</td>
</tr>
</tbody>
</table>

Throughout this report we have referred to a survey undertaken by NHS Employers. NHS Employers informed us that 48 employers responded to their survey. Most of these responses were on behalf of trusts or organisations, rather than from individuals.

A range of colleges and faculties also responded to our consultation, and many of these consulted their membership prior to responding.

**GMC News article**

The GMC News article generated a large amount of interest. 299 people provided an online comment in relation to the article.

We decided to analyse these responses to ensure that we took into account all of the themes raised in relation to our proposals. We kept the analysis of these comments separate from the core question by question analysis because the comments were based on a very short news article, it is not clear if the respondents read all essential information set out in our consultation document, and we are unable to identify any of the respondents.

While most of the comments were very high level, overall they reflected the key themes that emerged from the question by question responses. We have set out our summary of those comments in annex C.
Summary of findings

Demonstrating the necessary knowledge of English

Overwhelming agreement

There was a very high level of support for our proposals to ensure that European doctors had the necessary knowledge of English prior to granting a licence to practise in the UK. Respondents thought that the proposals were ‘logical’ and ‘essential’, and they highlighted patient safety and fairness to IMGs as some of the reasons for their support. A wide range of respondents also provided anecdotal evidence of why this change is necessary.

A small number of respondents disagreed with our proposals (less than nine per cent). Given the small number who disagreed with the proposals, we could not identify any overarching themes. However, we have set out below a summary of the two main reasons why respondents disagreed with our proposals.

Responsibility for ensuring the necessary knowledge of English

A number of respondents stated that it is the responsibility of employers, rather than the GMC, to ensure that doctors have the appropriate English language skills to undertake a particular role. Closely related to this point, several respondents suggested that different levels of language were required for different roles and therefore employers were best placed to undertake these checks. A range of examples were provided, including working in private practice, working as a specialist rather than a generalist, working with patients who do not communicate in English and working in non-clinical roles.

We agree that employers have a vital role in ensuring that doctors have the right language skills to undertake their role. Employers have told us that these checks are improving, but are still patchy and inconsistent, and that our proposals will strengthen their ability to deal more effectively with issues about language. It’s also worth noting that not all doctors have employers – some set up in private practice where there may be no one responsible for ensuring they have sufficient language skills. This was highlighted in the response from the Nursing and Midwifery Council.

We also agree that some roles may require a greater knowledge of English than others. We are responsible for granting doctors a licence to practise in the UK. The licence is generic and enables doctors to undertake a range of functions that are reserved by law to registered and licensed doctors. Therefore, it is essential to ensure that, when we grant a licence to practise, the doctor can communicate in English to a sufficient minimum standard. Even where a doctor does not deal directly with patients, they need to communicate with their colleagues and the wider healthcare service. Employers need to satisfy themselves that each doctor has sufficient English language skills to undertake their role, particularly where that role may require more sophisticated English language skills.

A small number of respondents did not think that the GMC should be responsible for ensuring that European doctors have the necessary knowledge of English because
they felt that this power would restrict the promotion of freedom of movement throughout the EU. While we agree that professionals should be able to move freely around Europe, this should never be at the expense of patient safety. Our legislative proposals comply with existing EU legislation as well as the new Directive 2013/55/EU which enables competent authorities like the GMC to assess the language competence of professionals after recognition of their qualifications but before granting them access to the profession.

Evidence required to demonstrate the necessary knowledge of English

Some respondents took issue with the evidence we suggested we are likely to accept as sufficient for demonstrating that a doctor has the necessary knowledge of English. Some felt that the evidence was not flexible enough, although others cautioned that study or work experience in English was not robust enough. There were a range of comments particularly about the International English Language Testing System (IELTS), for example stating it’s not the only test, it’s not specifically medical, or it’s too expensive.

The academic version of the IELTS test is widely accepted by employers, regulators and professional bodies as a means of assessing proficiency in English in a professional environment. It is widely available, with a significant evidence base behind it. It is also relatively inexpensive for candidates. However, we do recognise that alternatives are becoming available, so in October 2013 we went out to tender for a research partner to compare the available tests of English proficiency with IELTS and we are committed to keeping under review the language evidence we routinely accept in future.

Changes to the Act will require us to publish guidance relating to the information and documents to be provided for the purposes of demonstrating whether a person has the necessary knowledge of English. The GMC Registrar must have regard to this guidance when determining whether an applicant has demonstrated that he or she has the necessary knowledge of English. We will seek to ensure this guidance balances flexibility and proportionality for doctors while being sufficiently robust in terms of patient protection. Our guidance will provide indications about the evidence of English language proficiency that we are likely to accept, but the draft regulations also give the Registrar discretion to determine the acceptability of any evidence provided by an applicant. That evidence would need to be sufficiently robust and objective, and we will provide guidance and criteria to ensure doctors are clear about what is required.

In response to question 1, the number of respondents who wanted our proposals strengthened was more than double the number who disagreed with the evidence we are likely to accept.

Changes to Fitness to Practise Rules 2004

Majority support for proposals

In general, there was a very high level of support for our proposals for dealing with fitness to practise concerns arising from a doctor’s lack of knowledge of English. We
asked five questions in this section, of which four related to the use of language assessments to evidence fitness to practise concerns, providing an opportunity for respondents to comment specifically on compliance periods and costs. We also sought views on our proposals to indefinitely suspend doctors who repeatedly fail to demonstrate an acceptable knowledge of English over time.

The profile of respondents was not typical of fitness to practise consultations. An unusually high number of respondents were individual doctors and we received fewer formal responses from medical defence organisations compared to other similar exercises. The one response we received from this latter group indicated they were in favour of our proposals.

**Language assessments during a fitness to practise investigation**

Only 4.5% of respondents disagreed with our proposals to require doctors to undergo language assessment during a fitness to practise investigation and before restoration to the medical register where there are sufficient concerns about a doctor’s English language skills. Respondents were less sure about the detail of our proposals to require a doctor to comply with such a request within a 90 day period and opinion was divided on charging doctors, although there was no consensus on an alternative approach. Several respondents commented on the need for clear guidance for decision makers to ensure fairness.

**Indefinite suspension**

The majority of respondents (78.8%) agreed with our proposal to indefinitely suspend doctors who fail over time to acquire the necessary knowledge of English to safely treat patients in the UK. Those in favour included the British Medical Association (BMA) and the Professional Standards Authority (PSA), which recognised that this approach is consistent with our existing procedures for health cases. A summary of the PSA’s response to our fitness to practise proposals is provided below for ease of reference.

**Professional Standards Authority**

The PSA reports annually on our performance to parliament. As such, we thought it was important to include reference to their response in this section, as well as incorporating any themes in the question by question analysis in annex A of this report.

The PSA firmly believes that the GMC should be in a position to respond, through registration/licensing and fitness to practise mechanisms, to risks presented by doctors whose poor grasp of English prevents them from doing their job to a safe standard.

However, they were unclear why the current grounds for impairment are not adequate to address these language concerns. The Department of Health (England) consulted independently on these issues from 7 September to 2 December 2013, and they will publish their consultation report shortly. We have corresponded with both the PSA and Department of Health (England) on these issues. Communication
skills are in themselves a key domain of Good medical practice, our core guidance for doctors.

The introduction of a new category of impairment is intended to change the law so that failure to demonstrate the necessary language skills could lead to a finding of impairment – under the current arrangements this would only be possible where such a failure is connected to other concerns such as prescribing and record keeping. The proposed powers will strengthen our ability to gather the necessary evidence to demonstrate the need to take action to protect patients.

The PSA also raised the possible impact of these new powers on the volume of cases, particularly relating to doctors who share protected characteristics. Of course, it is difficult to be certain about this in advance of the introduction of these changes and other factors may have an effect. For example, as part of supporting the Department of Health’s business case for these changes, we provided evidence that suggested (though based on small numbers) that controls around English language capability as part of the application process for registration with a licence may, over time, drive down the numbers of fitness to practise cases where language capability is a contributory factor.

**Conclusions and next steps**

Overall there was a very high level of support for our proposals. The vast majority of respondents agreed that we should have the ability to ensure that doctors coming to work in the UK have the necessary knowledge of English to practise safely. There was also a high level of agreement that we should have appropriate powers to deal with any concerns that arise about licensed doctors.

We will consider carefully the findings of the consultation, and our Council will decide if any changes to the draft regulations are required. A range of comments were provided relating to fairness and proportionality which we will take into account in developing our guidance documents and online information.

We will work with the Department of Health (England) to finalise our rules and regulations throughout the first half of 2014.
Annex A: Question by question analysis

We received 269 responses that were set out in a question by question format. It was not compulsory to respond to every question, or to provide additional comments. 33 broader comments were also provided. These were not included in the statistical breakdown, but were included in the overall analysis of the comments.

In this annex we have set out each question, followed by the statistical breakdown of responses and a summary of all of the themes that arose from the comments provided by respondents.

A range of comments that are not directly relevant to the consultation questions, but were raised by respondents, are included at the end of this section for completeness.

Demonstrating the necessary knowledge of English

The first part of the consultation sought views on changes to our regulations that will give us the powers to ask for evidence of a European doctor’s English language skills before we grant a licence to practise in the UK.

All IMGs must demonstrate that they have the necessary knowledge of English before they can practise as doctors in the UK. We only grant registration with a licence to practise if they can do so. However, the law currently prevents us from asking European doctors to provide any evidence of their language skills.

The proposed change to the Act will allow us to seek evidence and confirmation of a European doctor’s ability to communicate in English, if concerns about their language skills emerge during the registration process.

While we will continue to recognise their qualifications by granting registration in the usual way, we are proposing that we will refuse to grant a licence to practise in circumstances where the doctor is unable to demonstrate that he or she has the necessary knowledge of English. We asked three questions about these proposals.

Question 1: Do you think it is fair and proportionate to require the same evidence of English language proficiency from European doctors as IMGs?

<table>
<thead>
<tr>
<th>Question 1</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Blank</th>
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<tbody>
<tr>
<td>Do you think it is fair and proportionate to require the same evidence of</td>
<td>244</td>
<td>16</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>English language proficiency from European doctors as IMGs?</td>
<td>90.7%</td>
<td>5.9%</td>
<td>1.9%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

The vast majority of respondents (over 90 per cent) agreed with our proposals. Of the 16 respondents who disagreed with the proposal, 11 were individual doctors. One organisation disagreed with our proposals. There was a very small number who were not sure.
143 respondents provided additional comments to support their responses to question 1. These demonstrated overwhelming support for this proposal. It is ultimately for the GMC Registrar to take a decision on whether a doctor has demonstrated they have the necessary knowledge of English. We currently publish guidance on what kinds of evidence IMGs can provide that is likely to satisfy the Registrar. However, our Registrar has discretion to determine the acceptability of any evidence provided by an applicant, and we will develop guidance with an aim to achieving consistency. We will seek to ensure this guidance balances flexibility and proportionality for doctors with being sufficiently robust in terms of public protection.

Comments in support of our proposals

The overwhelming majority of comments were in support of our proposals. Over 90 respondents provided a range of general comments to emphasise their agreement with this proposal. Many of these were very general, highlighting the importance of having the necessary knowledge of English. For example, one individual doctor said:

‘Being able to communicate easily with patients and with professional colleagues is an essential part of being a doctor. It is extraordinary that demonstrating an ability to speak a country’s major language is not a requirement for registration, not just in the UK but the rest of Europe as well.’

The British Medical Association said:

‘The British Medical Association (BMA) has emphasised the need for adequate communication skills and since 2002 has called for language skills to be made a pre-requisite for any doctor wanting to practice in another EU member state. Whilst the BMA is supportive of freedom of movement it recognises that patient safety is paramount and must not be compromised. All doctors, EEA or otherwise, must have an acceptable command of English and acceptable clinical skills to enable them to practise in the UK. The BMA agrees that it is both fair and proportionate to require the same evidence of English language proficiency from EEA doctors as International Medical Graduates.’

NHS Employers ran an online survey to gather employer’s views of our proposals. 96% of their surveyed respondents (48 employers in total) thought this proposal was fair and reasonable.

31 respondents who provided general comments in support of our proposal mentioned patient safely, or the reduction of harm to patients through errors and near misses, as a reason for agreeing with our proposals. One respondent stated that because patients are vulnerable, it is more important in medicine that professionals can communicate effectively in English than other professions. Several respondents said that the GMC has a duty of care towards patients to ensure that doctors are safe to practise, and some questioned why we were only introducing these proposals now. The Scottish Government stated:
Patient safety is of course paramount and it is essential that regulators and employers have appropriate powers to satisfy themselves that all healthcare professionals coming into the UK – whether from inside or outside the EEA – have the requisite language skills to allow them to communicate effectively with patients and their families, as well as colleagues.

20 respondents referred to their own experiences in supporting our proposal. This included a range of doctors commenting on the poor language skills they had encountered while working with some European doctors. One doctor said no one will report language concerns of European colleagues due to fear of political correctness and prejudice. If true, this is worrying as any concerns that could impact on patient safety should be raised through appropriate local channels or referred to us. Some IMG doctors explained how they had undertaken both IELTS and PLAB⁴ and found it beneficial to their practice in the UK. Several UK doctors shared experiences of working overseas and highlighted how important it was for them to be able to speak the language, and that they felt it was ‘entirely acceptable’ that they had been subject to language checks upon applying to work in another country.

A number of respondents mentioned the need for fairness and consistency between IMG and European doctors as their reason for agreeing with our proposals. This ranged from comments that all doctors coming to work in the UK should be treated the same, to allegations of unfairness or even discrimination against IMG doctors. One doctor shared their experience of European doctors being preferred over IMG doctors by employers. The word ‘discrimination’ appeared in eight responses. For example, one medical manager said:

‘the existing disparity is potentially discriminatory against IMGs since EEA doctors are not required to provide evidence of their English language ability’.

An individual doctor said:

‘High time to stop this discrimination. Most non EU doctors do their entire education (right from kindergarten) in English. Most use English for all their work and communication needs. Yet they have to prove their proficiency, while the EU doctors were exempted!’

A range of comments focused on the fact that many IMG doctors are taught in English, and therefore European doctors were a greater risk in terms of English language proficiency. Some went as far as suggesting that overall, IMGs have higher English language proficiency than European doctors, and therefore the language controls on European doctors could be stricter than the controls on IMGs.

⁴ More information about the Professional and Linguistic Assessments Board (PLAB) test is available on our website at http://www.gmc-uk.org/doctors/plab.asp.
Individual respondents provided these additional comments in support of our proposals:
- because health systems vary so much across Europe, it requires a high level of English to come and work effectively with patients in the UK
- it is a good way to restrict the number of doctors coming to work in the UK
- it is analogous to language testing of pilots.

While agreeing with our proposals, a significant number of respondents felt they could be further strengthened. A significant number of this group wanted us to require all overseas trained doctors without a UK primary medical qualification to demonstrate that they had the necessary knowledge of English as a matter of routine. Two comments from individual doctors represent this view:

’I would favour a stricter approach, where any medical graduate who did not achieve a primary medical degree in English should be tested as a matter of routine.’

’IELTS must be mandatory for all the doctors who want to work in the UK.’

A small number also suggested that they had encountered UK doctors with poor English language skills and raised the possibility of all UK doctors undertaking IELTS or language assessments as part of their qualifications.

Furthermore, several respondents stated that European doctors should also have to undertake an assessment of broader communication skills through an objective structured clinical examination. Two medical royal colleges highlighted that most IMGs are currently assessed on broader communication through the role-play assessment stations as part of the PLAB 2 test, as well as undertaking IELTS. The GMC is not able to require European doctors to undertake knowledge or skills based assessments as a condition of their registration. We discuss broader communication skills further at the end of this annex.

A small number wanted to see a higher level of English language proficiency across the board from all doctors coming to work in the UK. We have provided further information about how we are reviewing the minimum scores we accept in the IELTS test at the end of this annex.

One respondent referred to revalidation as a more powerful test, and another asked whether we have considered making an English language test mandatory for revalidation. We have discussed English language and revalidation further at question 3.

Two respondents thought we should apply the proposals retrospectively to European doctors already working in the UK, and another thought we should apply it to European doctors who had held a licence before. Another respondent suggested that the GMC provide feedback to those not granted a licence so that they would know where to focus their further development.
One respondent agreed in principle with our proposals but stated that ‘different roles require different levels of language skills’. A number of respondents provided this as a reason for disagreeing with our proposals, and further detail is set out below. On the other hand, the Royal College of Physicians specifically welcomed the fact that the requirements would apply irrespective of the level of contact that doctors might have with patients. The College highlighted the importance of communication, not only with patients, but in working effectively with colleagues.

Comments made about different types of evidence

At least 15 respondents provided comments on the different types of evidence we might require from doctors to demonstrate that they have the necessary knowledge of English. These included respondents who both agreed and disagreed with our proposal. Half of these respondents commented specifically on the IELTS assessment - that it was not the only test we should consider, that it was not the right test as it was not medically-orientated, or that the thresholds are not set at the right level. We have included further information about research to identify whether there are any other suitable assessments, as well as research to review the GMC’s IELTS thresholds, at the end of this annex.

Half of these respondents commented about evidence other than IELTS. A small number noted that the evidence we currently seek from IMGs was rigid and it may be possible to allow other evidence of the same weight. However other respondents also cautioned that evidence of undertaking study in English or working in an English-speaking environment was not sufficiently robust. The GMC’s Registrar has discretion to determine the acceptability of any evidence provided by an applicant. However, that evidence would need to be sufficiently robust and objective, and we will provide guidance to ensure doctors are clear about what evidence is likely to be acceptable.

One respondent stated that the necessary knowledge of English should be set at the level that patients thought correct, not what doctors or regulators thought correct. One respondent also proposed that European doctors should be able to work in the UK for a year with a preliminary licence and get feedback on their language skills during that time. The GMC is not able to grant a preliminary or restricted licence.

It’s worth noting that the number of respondents who wanted our proposals strengthened was more than double the number who disagreed with the evidence we currently accept from IMG doctors.

Comments from respondents who did not agree with, or were not sure about, our proposals

In addition to the comments on evidence, 16 respondents provided further reasons why they were either not sure about, or disagreed with, our proposals. Some respondents stated that the proposals restricted the purpose of EU law to promote freedom of movement throughout the EU, and that European doctors had a right to be treated differently or more advantageously than IMG doctors. Some felt that any language controls should be EU-wide, rather than at a national level. While we agree that professionals should be able to move freely around Europe, this should never be
at the expense of patient safety. Our legislative proposals comply with existing EU legislation as well as the new Directive 2013/55/EU which gives powers to competent authorities like the GMC to assess the language skills of professionals after recognition of their qualifications but before granting access to the profession.

There were also suggestions that it is an employer’s responsibility to ensure that doctors have the necessary language proficiency on recruitment. These comments were closely linked to suggestions that some jobs require greater language proficiency than others and that some doctors will only treat nationals from their own countries or may undertake roles with no patient contact at all. Some respondents noted that not all patients speak English.

We agree that some roles may require a greater knowledge of English than others. However, we believe that it is essential for all doctors who work within the UK healthcare system to be able to communicate in English to a minimum standard. Employers need to satisfy themselves that each doctor has sufficient English language skills to undertake a particular role.

We have also made clear that we will only require evidence of English language competence where we have a cause for concern. There may be some doctors, such as doctors travelling with their national sports team, where a cause for concern is unlikely to arise in the same way as a permanent registrant treating patients in the UK more generally over a prolonged period of time.

There were further comments made by very small numbers of respondents.

- Two respondents made comments in relation to cost. One felt that any language test should be paid for by the GMC so as not to disadvantage those from poorer countries. Another felt that this proposal may result in an increase in registration costs which may reduce the number of doctors choosing to work in the UK. We have confirmed that although the cost of undertaking any language assessment will rest with the individual doctor, any further costs related to the assessment of language skills will be met by the GMC.

- Two respondents felt the proposals were driven by a recent high profile case where employers had failed to ensure that a doctor had sufficient language skills.

- One respondent commented that it was unfair on European doctors to have to demonstrate their knowledge of English as most European doctors did not have English as their first language, unlike many IMGs. Another respondent commented that it was unfair because most European doctors had English exams as part of their qualifications and most studied English throughout their education.

- One questioned why these proposals are only necessary for medicine and not for other professions.
Further comments not directly related to Question 1

A small number of additional comments did not directly relate to the question we posed but are included for completeness.

- One respondent made a general comment about the purpose of language tests.
- One respondent explained that the system in France consists of a face to face meeting with the regulator, rather than a formal test.
- Two respondents questioned the existing evidence requirements for IMGs. We have included further information about relevant research we will be undertaking at the end of this section.
- One respondent commented that immigration laws in general favour European doctors over IMGs.
- One respondent referred us to an article about a survey of opinions of trainers, trainees and service users regarding communication skills of overseas doctors in psychiatry, which recommended additional formalised language training.

Question 2: Do you agree that we should not grant a licence to practise to a European doctor when they have been unable or unwilling to show they have the necessary knowledge of English to practise safely in the UK?

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<th>Question 2</th>
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<tr>
<td>Do you agree that we should not grant a licence to practise to a European doctor when they have been unable or unwilling to show they have the necessary knowledge of English to practise safely in the UK?</td>
<td>237</td>
<td>18</td>
<td>7</td>
<td>7</td>
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<td></td>
<td>88.1%</td>
<td>6.7%</td>
<td>2.6%</td>
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We received a very high level of support for this proposal. Of those who disagreed, 12 were individual doctors. One organisation disagreed with this proposal. There was a very small number who were not sure.

94 respondents provided comments to support their response. Overall, the comments reflect similar themes to those in question 1.

Comments in support of our proposals

We received 57 general comments in support of our proposals. The majority of those comments simply stated their support. 18 respondents specifically mentioned patient safety as a reason for supporting our proposal. One highlighted that the ultimate priority is patient safety and that misunderstandings on either side would compromise this. One doctor raised the importance of language skills with the increase in shift work and rotations in medicine today and another said they had patients who had not understood what their consultant had told them.
A number of these respondents specifically referred to fairness in their comments. Some felt that it was a fair proposal because we will treat European doctors in a similar way to IMGs. Others felt that the process was fair - any doctor not granted a licence can improve their English language skills and re-apply. They will receive a partial refund of their registration fee and have the opportunity to appeal if they disagree with the decision.

A small number of respondents suggested that, if a doctor was unwilling to demonstrate their English language skills, that would raise concerns in itself. One respondent thought that we should be stricter with European doctors as they are generally not educated in English, and another called for them to undertake both IELTS and PLAB. One European doctor explained how they had been required to achieve a score of 7.5 to get onto the UK Foundation Programme and thought this should be required for any application to the GMC. We currently require a score of 7 across all four elements of IELTS and we are undertaking research to review these thresholds. More information on this is included at the end of this annex.

Two respondents (including an NHS organisation) highlighted that English language skills are not just important in communicating with patients, but are essential for communication with colleagues and within the wider UK healthcare system.

Three respondents, including the BMA, highlighted the importance of the GMC providing guidance to doctors on these changes and ensuring that they were publicised sufficiently, with timetables, for prospective applicants. The PSA suggested that we continue to raise awareness of the difference between holding registration with a licence and registration without a licence. We will provide a range of guidance to complement the information currently on our website.

Comments on the required evidence

We received 12 comments in relation to the evidence we are likely to accept as demonstrating that a doctor has the necessary knowledge of English. This is based on the evidence that we currently accept from IMGs. These comments reflect the comments made in response to question 1 and were from respondents who agreed with our proposals, as well as those who disagreed or were not sure.

There were a number of negative comments about IELTS – that it was stressful and too difficult for doctors who do not have English as their first language, that the thresholds should be lowered and that doctors should have more than one chance to pass the test. One respondent commented on the cost of IELTS and one felt that overall, this proposal would increase the cost of registration with the GMC. While the cost of taking the test where deemed necessary will rest with the doctor, we have committed to absorbing any extra costs arising from implementing these proposals. The BMA agreed that, where a doctor is required to undertake a language assessment for the purpose of granting a licence, the individual doctor must bear the cost of the assessment.

One respondent questioned the time limits placed on doctors to provide us with the necessary evidence, one thought there might be other tests that could be equally acceptable and another asked for greater flexibility for native English speakers.
However, one respondent suggested that being taught and examined in English should not be sufficient and felt it was essential for the doctor to have had at least 75% of patient interactions in English as part of their training.

One respondent wanted us to develop our own language assessment to specifically assess English in a medical context. Another suggested we differentiate between doctors with different levels of English, for example providing a combined exam where language and consultation skills are tested together, but only test the consultation skills of doctors who do not have a language certificate (such as TOEFL\textsuperscript{5}).

*Comments about responsibility for ensuring English language skills*

Overall, six respondents commented specifically on who they thought was responsible for ensuring that doctors have the necessary knowledge of English. Three strongly felt it was a responsibility of the GMC. One doctor said that the GMC would be ‘failing in their duty of care to do otherwise’. Another suggested that it was not the employer’s area of expertise, it would be a waste of resources to expect each employer to develop a checking system, and doctors would then have to undertake checks each time they applied for a new job.

Two respondents disagreed with our proposal on the grounds that it was the employer’s responsibility, not the GMC’s, to check whether language skills were appropriate for the post. One respondent agreed with our proposal but agreed that employers also have a duty of care.

*Comments that did not agree with, or were not sure about our proposal*

There were a number of other reasons why some respondents did not agree with our proposal. Two felt that the proposals were not fair because we were still treating European doctors more favourably than IMGs by proposing to continue to grant registration when they cannot demonstrate their English language capability. However, we are legally required to recognise European doctors’ qualifications and grant them registration.

Three respondents disagreed with our proposals because they felt that different levels of communication are required for different roles. For example, one stated that conversations with a specialist are more limited than conversations with a generalist.

Four respondents felt that our proposals would breach EU law, that we should treat European doctors differently and that there should be European-wide standards on language rather than national-based assessments. One thought that the GMC should pay for any assessment. Two respondents thought the proposals might have an impact on the medical workforce - some doctors may be deterred from coming to work in the UK, or it may be more difficult to fill gaps with European doctors. We

\textsuperscript{5} TOEFL is an English language test. More information is available at [http://www.ets.org/toefl](http://www.ets.org/toefl).
continue to believe that patients will be put at risk if gaps in the workforce are filled by doctors who are not be able to communicate effectively in English.

Six respondents who selected no or not sure to the proposal set out in question 2 provided suggestions of alternatives to a refusal to grant a European doctor’s licence. Three respondents suggested either a restricted licence or a period of supervision where the employer would supervise the doctor’s language skills. Other suggestions were to:

- allow these doctors to only carry out certain work, such as private practice
- have an interview with the GMC
- have an oral or non-formal test with the employer
- lower the IELTS scores for provisional registration, and then raise them when the doctor applies for full registration.

At the end of this annex we have set out various pieces of research that we either have undertaken or will be undertaking in relation to evidence of English language skills.

**Question 3: Do you agree that it is fair and proportionate to be able to ask doctors who have no responsible officer or suitable person to demonstrate they have the necessary knowledge of English where we have a concern, as part of their revalidation?**

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<tr>
<th>Question 3</th>
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<tr>
<td>Do you agree that it is fair and proportionate to be able to ask doctors who have no responsible officer or suitable person to demonstrate they have the necessary knowledge of English where we have a concern, as part of their revalidation?</td>
<td>228</td>
<td>22</td>
<td>12</td>
<td>7</td>
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</table>

84.8% 8.2% 4.5% 2.6%

The majority of respondents supported this approach. Of those who disagreed, 18 were individual doctors, and one was an organisation. Of those who were not sure, 10 were individual doctors.

80 respondents provided comments to support their response.

**Comments in support of the proposal**

25 respondents provided general comments supporting the proposal, the majority of them were statements of agreement. Four cited patient safety as a reason for their agreement with the proposal; two felt it was important to close this loophole and one agreed as there was no one else to raise these concerns. The Nursing and Midwifery Council stated:

'Yes we agree. The purpose of revalidation is to ensure that health professionals have the knowledge and skills to continue to practise safely. Effective language and communication skills are integral to the safe practice of all healthcare professionals
and where there is a concern, demonstration of its proficiency is as important as the demonstration of other knowledge and skills. We would see this as a proportionate and evidenced approach.’

Another respondent stated:

'Most doctors will have a connection, those that don’t should be checked out a little more closely to ensure a loop hole isn’t being used to avoid English language testing. I’d expect the same if I tried to practise medicine in a country where I couldn’t speak the language.’

Several respondents said we should apply this proposal to all doctors, including UK graduates. One respondent stated that all European doctors should undertake both PLAB and IELTS.

The PSA agreed with this proposal. However, they went further by stating that:

‘in the vast majority of cases, revalidation mechanisms are likely to be a more proportionate means of addressing the problem of licensed EEA doctors whose English language skills may not be up to standard than through fitness to practise measures.’

Proportionality and fairness

A range of respondents made comments in relation to the proportionality of the proposal by providing conditional agreement, or suggesting that the proposed change might be unnecessary in particular circumstances. These were a mixture of respondents who agreed, disagreed, or were not sure about our proposal. Half of these respondents thought that the proposal was proportionate as long as the additional checks were based on a concern about the English doctor's language skills, such as a concern raised though appraisal.

One respondent stated:

'It would depend on the situation. If they have passed English language tests in the past, or trained in an English-speaking country then no unless the former situation was a long time ago and there were reasons to be concerned about the English language skills’

Other respondents set out the following comments in relation to proportionality.

- It would be disproportionate to repeat checks every five years, or on a routine basis.
- Any checks should be limited to the first revalidation cycle. Once the doctor has demonstrated the necessary knowledge of English there should not be further checks.
- Where the doctor was already working in the UK, or had already demonstrated the necessary knowledge of English, then their language skills would only improve over time, and therefore it was not necessary to check again.
■ It’s too late to check at this stage – it should have been done at the point of registration or prior to employment.

■ It will increase revalidation requirements and paperwork, and make doctors less likely to want to work in the UK.

■ A better option would be to get a reference from the doctor’s colleagues, to provide similar assurance to a responsible officer.

■ It would not be necessary if the doctor does not require English for their role.

■ It would only be necessary if there had been patient complaints.

Eight respondents highlighted impacts on certain groups of doctors, or raised concerns about potential discrimination. The groups of doctors identified were the doctors most likely to not have a responsible officer such as doctors working overseas, retired doctors, academic and research doctors. One stated that we might appear to be penalising those who had already slipped through the system. Another respondent said we should not limit this proposal to doctors where we have a concern, but apply it to all doctors to avoid discrimination. One respondent suggested that we select an ‘annual sample with representative proportions of EU and non-EU’ to check as part of their revalidation.

As part of our on-going work in relation to revalidation, we ran a ‘making connections campaign’ to help us to better understand the circumstances of doctors without a responsible officer. We monitor the data and trends and ensure any proposals and guidance for doctors without a responsible officer take into account the needs of the various cohorts of doctors that make up this group.

Identification of concerns

A number of respondents questioned how we would identify these concerns in the absence of a responsible officer. One doctor said:

‘It is not clear how you would become aware of any concern and who would raise any concern. If the poor knowledge of English affects the doctor's practice, it would be appropriate to further assess.’

One respondent questioned whether the proposal was due to concerns being raised about a doctor’s English language skills, or because they had no responsible officer. Some of these respondents stated that the GMC needed to define ‘concern’. One respondent asked about the link between identifying concerns through revalidation, and fitness to practise processes.

Other comments relevant to question 3

There were a number of suggestions in relation to revalidation in particular. One respondent said we should make ‘the necessary knowledge of English’ a standard of revalidation. It is worth noting that once the new ground of impairment is in place, language skills will explicitly be part of revalidation – the RO will, through their revalidation recommendations, confirm that there are no unaddressed concerns about the doctor’s fitness to practise. This will include concerns about language.
Other comments in relation to revalidation included:

- two suggestions around linking English language proficiency with the appraisal process
- that the suitable person route is less robust than responsible officers, and therefore we need to ensure they are aware of their responsibilities in relation to language
- questioning how doctors with no responsible officer or suitable person will revalidate
- the suggestion that we should give all doctors a responsible officer.

Two respondents asked about IELTS and its two-year validity, why that is the case, and how that would work with a five-year revalidation cycle. Three respondents highlighted broader communication requirements. We have provided more information about communication at the end of this section. One respondent asked that the GMC provide a range of training courses for doctors. One respondent said that overseas doctors would simply relinquish their licence and therefore avoid revalidation. The GMC has a range of powers in place to ensure this does not create a loophole.
Changes to Fitness to Practise Rules 2004

The second part of the consultation sought views on changes to our rules that will enable us to take action in relation to doctors who are already registered and licensed where concerns are raised about their language skills.

When we receive a serious complaint about a doctor’s ability to communicate with patients and other health professionals, we undertake an investigation to decide whether it is necessary to take action to protect the public. We proposed to make some changes to how we do this, where communication problems seem to arise from a doctor’s insufficient knowledge of English. These include requiring doctors to undertake a language assessment to support a fitness to practise investigation where there are relevant concerns and indefinitely suspending doctors who repeatedly fail to improve their skills over time. We asked five questions about these proposals. A summary of responses to each question is provided below.

**Question 4: Do you agree that if there is a serious concern about a registered doctor’s knowledge of English, we should have the power to require a doctor to undergo a language assessment?**

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<tr>
<td>Do you agree that if there is a serious concern about a registered doctor’s knowledge of English, we should have the power to require a doctor to undergo a language assessment?</td>
<td>234</td>
<td>12</td>
<td>12</td>
<td>11</td>
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<tr>
<td></td>
<td>87.0%</td>
<td>4.5%</td>
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A significant majority of respondents (87%) supported our proposal to require doctors to undergo a language assessment where there is a serious concern about their knowledge of English. The BMA, six Royal Colleges, the majority of individual doctor and patient respondents were among those in favour. There is a broad consensus that to ensure fairness, clear guidance is needed to support a proportionate approach to deciding when a language assessment is necessary.

A small minority of respondents (4.5%) did not agree, citing reasons such as risk of unfairness towards non-UK nationals who will already provide evidence of language competency at point of registration. One respondent suggested our powers to test doctors should only apply where English is necessary for the job they are employed to do. The PSA favoured a holistic approach to testing knowledge of English as part of a wider performance assessment. This view was supported by some individual doctors.

A question of impairment by reason of insufficient language skills will only arise where this impacts upon the doctor’s ability to practise medicine thereby putting patients at risk. The proposed powers also permit language testing as part of a wider performance assessment.
Overall approach

In general, those in favour regarded our proposals on language assessments as common sense. The Nursing and Midwifery Council (NMC) welcomed the changes, saying “effective language and communication skills are integral to the safe practice of all healthcare professionals.” They believe all health and social care regulators should have the power to carry out language assessments of health professionals. Centralised checks and controls via regulatory bodies were also seen as crucial to safeguard patients as many individuals work outside the NHS and formal management systems.

Threshold for testing

Several respondents commented on the threshold for requiring a doctor to undergo a language assessment as part of a fitness to practise investigation. There was a broad consensus that we need to develop a clear definition of ‘serious concerns’ in the context of language proficiency to ensure fairness and support impartial, objective decision making.

There were a wide range of views on what constitutes a serious concern. One respondent suggested that evidence of multiple, dangerous failings in communication should be provided before any action is taken on the part of the GMC. On the other hand, a Local Medical Committee suggested that ‘reasonable’ rather than ‘serious’ concerns should trigger investigation of the risk posed to patient safety arising from language difficulties. Many respondents felt that knowledge of English should be considered in the wider context of effective communication skills in a clinical setting.

Fairness and proportionality

Some respondents raised concerns about the role of personal bias in triggering and handling complaints. There was a broad consensus that training and guidance for decision makers is crucial to ensure referrals for language assessments are fair, proportionate and based on evidence of serious concerns.

The timing and frequency of language assessments was also discussed by several respondents. Some individual doctors and representative bodies said repeated requests for doctors to undergo language assessments may not be fair, particularly where doctors have presented evidence of language competency at point of entry to the register.

The BMA argued that careful thought should be given to ensure that where the underlying cause of language deficiencies is linked to professional or personal issues, this is identified and addressed.

Equality issues

One individual doctor raised concerns about the impact of our proposals on doctors with health concerns, for example where an underlying medical condition may be linked to deterioration of knowledge of language.
Several respondents commented on the impact of proposals on doctors practising medicine in Wales. The Chair of the Welsh Language Medical Society raised the importance of doctors’ ability to communicate in Welsh to Welsh patients and appropriate testing where necessary to provide safeguards. One individual doctor suggested that some Welsh doctors may need support to prepare for an English language assessment.

An advisor to European doctors seeking to practise medicine in the UK raised concerns about overseas doctors’ ability to navigate the UK legal system to appeal unfair decisions.

*Mechanisms for language assessment*

There was some discussion about the validity and effectiveness of different mechanisms for language assessment. Many respondents’ support for our powers to require doctors to undergo testing was dependent on selection of an appropriate tool to deliver fair outcomes and safeguard patients. Concern about the use of IELTS for English language assessment in fitness to practise cases was shared by a number of respondents. The method for testing a doctor’s knowledge of English did not form part of this consultation and further research is being undertaken to explore alternative mechanisms for language assessment. Further information is available at the end of this annex.

**Question 5: Do you agree doctors should pay the cost of a language assessment where there is a relevant fitness to practise concern?**

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<td>Do you agree doctors should pay the cost of a language assessment where there is a relevant fitness to practise concern?</td>
<td>142</td>
<td>66</td>
<td>50</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>52.8%</td>
<td>24.5%</td>
<td>18.6%</td>
<td>4.1%</td>
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Opinion was divided on plans to charge doctors for language assessments required as part of a fitness to practise investigation. A slim majority (52.8%) of respondents said they support the proposal. Several respondents agreed only if costs are reasonable and refunds applicable where no serious issues are evidenced by the assessment outcome.

24.5% of respondents said they oppose plans to charge doctors for language assessments required as part of a fitness to practise investigation. The PSA also questioned the proposal on the grounds of fairness. This question elicited more ‘unsure’ responses than any other question in the fitness to practise section of the consultation (18.6%). Of those who said they were unsure, 19 respondents submitted additional comments which indicate they did not support charging doctors for language assessments in the circumstances envisaged in the consultation paper. 42 e-consult respondents stated that the costs of language assessments should be met by the GMC. A theme amongst this group was that there needs to be parity with our approach to charging for other assessments undertaken as part of a fitness to practise investigation.
Respondents in favour of our proposal

52.8% of respondents support proposals to charge doctors for language assessments undertaken as part of a fitness to practise process. Those in favour included doctor and patient representative bodies, individual patients, medical managers, six Royal Colleges, the Medical Women’s Federation, Independent Doctors Federation, NHS European office and an advisor to European doctors seeking to work in the UK. An online survey run independently by NHS Employers found 67% of employers agreed with this approach.

Views were split among individual doctors. Just over half of respondents in this category agreed with our proposals to charge doctors. One individual doctor suggested that those subject to a fitness to practise investigation should personally bear costs for all necessary assessments, including performance.

Of those in support, five respondents suggested doctors should receive a refund if the assessment identifies no serious issues or complaints are found to be motivated by personal bias. One respondent suggested the need for an appeals process. Support among a few respondents seems to be based on a misperception that charges relate to tests undertaken in order to be granted a licence. The regulations do provide that testing at point of licence is at the doctor’s own cost. However this specific question only addresses costs in relation to FTP language assessments.

Respondents opposed to our proposal

24.5% of respondents opposed our proposals to charge doctors for language assessments undertaken as part of a fitness to practise process, including the National Clinical Assessment Service (NCAS). The PSA advocated parity with our cost arrangements for health assessments. The BMA also disagreed with the proposal on the basis doctors are not asked to pay for other assessments required by the regulator to support their investigation.

Around one quarter of individual doctors were opposed to this proposal (59 of 219 e-consult and offline respondents). Issues included fairness particularly where no impairment is later found, a call for parity with our charging policy in health and performance cases, affordability for doctors under financial strain and value for money for doctors who pay the registration fee. There was particular discomfort around doctors with established UK medical careers being asked to pay for a language assessment, or where the underlying cause of language deterioration is health.

Several in this group supported reimbursement if the doctor performed satisfactorily on assessment. A small minority of individual doctors raised concerns about the risk of non-UK nationals being deterred from choosing to work in the UK. One individual doctor raised concerns about a perception of discrimination where doctors who provided evidence of language competency at point of registration are asked to meet the cost of repeat tests.
Two individual patients/members of the public opposed this proposal. Due to the small number of responses received from individual patients and members of the public (5), it was difficult to estimate the strength of these views among the wider population.

33% of the 48 respondents to the online NHS Employers survey, one NHS organisation and one independent sector health providers said they opposed proposals to require doctors to pay costs for a language assessment. A range of other concerns were also raised by a significant minority of respondents.

**Respondents unsure about our proposal**

18.6% of respondents (50) said they were unsure about proposals to charge doctors for language assessments. This group included 42 individual doctors, two Royal Colleges, a former Training Coordinator for Refugees and Overseas Health Professionals. Within this group there appeared to be some confusion about the circumstances in which doctors might be expected to pay costs at specific stages of the registration and fitness to practise process.

Of those who said they were unsure, 10 respondents (including bodies representing doctors) stated that our charging policy for language assessments should be consistent with other mandatory assessments such as performance and health. 19 respondents submitted additional comments which indicate they do not support charging doctors for language assessments in the circumstances we envisaged in the consultation paper - in some cases making comments about the availability of a refund, and in other cases appearing to be under the misunderstanding that the question related to costs incurred where the doctor applies for a licence. Concerns were also raised about the risk of unfairness for doctors who are subject to a malicious referral, and the impact on doctors experiencing poor health.

**Suggestions for alternative funding mechanisms**

Several respondents proposed alternative funding arrangements for language assessments. 42 e-consult respondents suggest that the GMC should meet the cost of a language assessment where there is a fitness to practise concern as the burden of proof rests with us. Other suggestions included costs being met by the Department of Health, employers, or the organisation or person raising concerns.

Many respondents felt the appropriateness of charging doctors for language assessments where there is a relevant fitness to practise issue depends on the circumstances of the case. Several respondents suggested refunds for doctors where the outcome of a language assessment does not raise serious issues and waiving charges if health is an underlying cause of concerns.
Question 6: Do you agree that 90 days is a reasonable time period for doctors to comply with a direction to undertake a language assessment?

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<thead>
<tr>
<th>Question 6</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
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<tbody>
<tr>
<td>Do you agree that 90 days is a reasonable time period for doctors to comply with a direction to undertake a language assessment?</td>
<td>172</td>
<td>40</td>
<td>45</td>
<td>12</td>
</tr>
</tbody>
</table>

The majority of respondents (63.9%) supported proposals to introduce a 90 day compliance deadline for doctors required to undertake a language assessment. Those in favour included three Royal Colleges, 151 doctors, and the majority of members of the public who provided a response (4). Of those respondents who considered that 90 days is not an appropriate timescale (14.9%), there was no consensus on an alternative proposal but many felt relevant factors included individual circumstances and availability of assessments. Several respondents, including the Royal College of Surgeons Patient Liaison Group, raised concerns about patient safety where a doctor is allowed to continue practising during this period.

There was a relatively high proportion (16.7%) of ‘unsure’ responses to this question. A significant number of respondents who said they were unsure, including the BMA, did not feel they sufficiently understood the process to provide an informed decision.

Some respondents, including the PSA, opposed proposals to require doctors to undergo a language assessment and therefore did not comment on appropriate compliance periods.

Respondents in support of our proposal

In general, most respondents (63.9%) were in favour of a 90 day compliance period, including NCAS and the NHS European office. The Royal College of Physicians said that 90 days should be “ample” time for doctors to comply with a direction to undertake a language assessment. This view was shared by one medical manager who argued 90 days provides sufficient time to undertake preparation and mock examinations.

The NMC and one individual doctor observed that this approach will help to promote greater consistency in our processes for European doctors and IMGs.

Respondents opposed to our proposal

Stakeholders who disagreed include one Local Medical Committee and two Health Education organisations based in London. Among those opposed to our proposal there were a wide range of views on alternative compliance deadlines, with opinion divided on whether the proposed 90 day period is too long or too short. Some respondents suggested that a period of 30 to 60 days would offer greater protection for the public, provided that tests are available within this timeframe. Several respondents suggested that language assessments should be undertaken immediately.
Some respondents raised concerns about the adequacy of preparation time to improve performance prior to an assessment, and signposting to recommended centres for appropriate tuition. One individual doctor suggested doctors should be allowed greater discretion about the timing of a language assessment in order to prepare provided they are willing to cease medical practice until the matter is resolved. Others suggested that a flexible approach should be applied to doctors who work abroad for part of the year. The proposals do provide for the exercise of discretion on taking action for non-compliance in the light of the individual circumstances of the case.

**Fairness and proportionality**

Fairness and proportionality was the most common theme across comments from those respondents who answered ‘no’ or ‘unsure’ to this question. Several respondents felt the timeframe for the completion of an English language assessment should take into account the individual circumstances of each case. A European advisor to doctors seeking work in the UK favoured a more flexible approach requiring compliance within one year.

The BMA supported this view and suggested consideration should be given to making “reasonable adjustments“ for doctors with a disability or health concern. Two individual doctors suggested that the timeliness of our investigation may be a potential stressor for doctors. Another respondent said “there should be a concession where...the doctor can prove that he/she has been unable to secure an assessment date within [the compliance] period.”

**Patient safeguards**

Several respondents raised concerns about the need to mitigate patient safety risks arising from doctors practising medicine pending the outcome of a language assessment. The Royal College of Surgeons Patient Liaison Group, Royal College of Anaesthetists and NHS Employers considered that if a doctor is allowed to practise during this period, there could be a patient safety issue. This view was also shared by a small minority of doctors who believed that doctors should be temporarily suspended while concerns about their knowledge of English are investigated.

**Question 7: Do you agree that we should be able to indefinitely suspend doctors who fail over time to acquire the necessary knowledge of English to safely treat patients in the UK?**

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<thead>
<tr>
<th>Question 7</th>
<th>Yes</th>
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<th>Not sure</th>
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<tbody>
<tr>
<td>Do you agree that we should be able to indefinitely suspend doctors who fail over time to acquire the necessary knowledge of English to safely treat patients in the UK?</td>
<td>212</td>
<td>28</td>
<td>19</td>
<td>10</td>
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<tr>
<td></td>
<td>78.8%</td>
<td>10.4%</td>
<td>7.1%</td>
<td>3.7%</td>
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</table>
The majority of respondents (78.8%) supported our proposals, including the PSA, four Royal Colleges and 176 individual doctors who provided a response. The responses we received from members of the public and patients were also broadly positive. A number of respondents voiced concerns about the need to take a fair and proportionate response to decisions, and consider action on a case by case basis.

**Respondents in support of our proposal**

The PSA supported our proposal to indefinitely suspend doctors who fail over time to acquire the necessary knowledge of English to safely treat patients in the UK as this approach is consistent with our existing procedures for health cases.

Some respondents believe that doctors should be given clear timescales for improving their language skills before a decision is made to indefinitely suspend their registration.

**Fairness and proportionality**

There was a consensus that decisions need to be fair and proportionate with consideration given to the individual characteristics of each case. Several respondents suggest that the medical regulator has a role in supporting doctors to return to practice.

A number of respondents who supported our proposals suggested that adequate procedures need to be in place to ensure that any suspension is lifted as soon as the doctor has provided evidence they have sufficient knowledge of English to safely treat patients.

The BMA raised concerns about the effect an indefinite suspension may have on a doctor’s ability to work outside of the UK, where English language is not a requirement.

**Respondents opposed to our proposal**

10.4% of respondents opposed our proposals to indefinitely suspend doctors, including the Royal College of Physicians of Edinburgh. Within this group, five respondents suggested alternative action such as restrictions on a doctor’s registration or a fixed period of suspension may be more proportionate. One respondent raised concerns that indefinite suspension may be perceived as punitive action. Some opposition to this proposal seems to be based on a misunderstanding of how the powers will operate in practice, and the relationship between the GMC and the Medical Practitioners Tribunal Service (MPTS)\(^6\).

\(^6\) The Medical Practitioners Tribunal Service is the new adjudication service for UK doctors. More information is available online at http://www.mpts-uk.org/
There was some disparity evident in the few comments we received from members of the public. One respondent considered that English language skills would never raise sufficient patient safety concerns to warrant indefinite suspension. Another respondent believed that where a doctor fails over time to acquire the necessary knowledge of English to safely treat patients in the UK, they should be erased from the register.

**Question 8: Do you agree that we should be able to ask doctors to undergo a language assessment when they apply to be restored to the register if there is a concern about their language skills?**

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<th>Question 8</th>
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</thead>
<tbody>
<tr>
<td>Do you agree that we should be able to ask doctors to undergo a language assessment when they apply to be restored to the register if there is a concern about their language skills?</td>
<td>230</td>
<td>12</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>85.5%</td>
<td>4.5%</td>
<td>7.1%</td>
<td>3.0%</td>
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A strong majority of respondents (85.5%) supported our proposals to require doctors to undergo language assessment prior to restoration where there are serious relevant concerns, including most employers, individual doctors and their representative bodies. 4.5% of respondents disagreed with our proposals, and 7.1% of respondents were unsure. Both the PSA and BMA raised questions about whether we should refuse a restoration application due to language concerns if the doctor had previously been registered and licensed with no concern about their language skills. Several respondents identify the need for checks and balances to ensure our procedures are applied fairly and avoid bias against doctors with protected characteristics.

**Respondents in support of our proposal**

85.5% of respondents were in favour of this proposal. Those in favour included the BMA, six Royal Colleges and 188 individual doctors who provided a response. The comments we received from members of the public and patients were broadly positive. Within this group, there was a consensus that concerns about a doctor’s language skills must be sufficiently serious to warrant a language assessment. One respondent suggested it is only appropriate to ask the doctor to undergo a language assessment prior to restoration if they were previously erased for reasons linked to language concerns.

In addition, a separate online survey of employers conducted by NHS Employers found 97% of 48 respondents agreed with this proposal. Among employers, opinion was divided on whether fitness to practise concerns must be present to trigger a language assessment when a doctor applies for restoration. A slim majority (54%) of respondents to the NHS Employers survey agreed a language assessment should only be undertaken at restoration if there are relevant concerns. Approximately one third (32%) felt an assessment would only be appropriate where doctors have previously been involved in a fitness to practise case linked to language or communication. Around one-tenth of respondents (11%) suggested widening the
proposed approach to require all doctors to undertake a language assessment prior to restoration.

**Concerns about our proposal**

4.5% of respondents disagreed, and 7.1% of respondents were unsure about our proposals for dealing with language concerns when a doctor applies for restoration. The BMA suggested that doctors should only be asked to undergo a language assessment on application for restoration if an investigation finds there is a case to answer in response to a specific complaint. Where there are concerns following the results of a language assessment the matter should be referred to a restoration hearing for consideration, with specific details of the allegations provided to the doctor in writing, in advance.

The BMA also considered that where a doctor has been removed from the medical register for reasons not linked to language concerns, they should not be asked to prove their knowledge of English when applying for restoration. The PSA suggested that refusal to restore doctors due to a new concern about their language skills where there are no previous relevant issues, may be open to legal challenge.

Some opposition to this proposal from individual doctors seems to be underpinned by a misperception that doctors may be asked to undertake a language assessment to support a restoration application where there are no relevant concerns. One individual doctor suggested doctors with language concerns could be restored to the register and allowed to practise medicine under supervision.

**Fairness and proportionality**

Several respondents highlighted the need for checks and balances to ensure requests for language assessments are fair and without bias against those sharing protected characteristics.

One respondent, an advisor to European doctors seeking work in the UK, raised concerns about the possibility of a disproportionate impact on European doctors who relinquish UK registration between periods of work in other EU countries. To ensure fairness, the BMA suggested we take steps to notify all doctors leaving the register they may be required to undergo a language assessment at point of restoration.

**Alternative evidence of language competency**

A small number of respondents suggested we consider alternative evidence of a doctor’s language competency such as employment history, or postgraduate qualifications where the course was taught in English. One respondent recommended the Royal College of General Practitioners Clinical Skills Assessment, which is used by the London Deanery to assess doctors returning to general practice. There are a range of views about the validity of different approaches to language assessment and the PSA suggests we keep arrangements under review.
Other comments not directly relevant to individual questions

A range of comments were provided that were not directly relevant to any of the questions we asked in the consultation, but which were relevant to the overall theme of our consultation. Therefore, we have provided a summary of those comments here.

Communication

We received a range of comments relating to communication more broadly. These highlighted that communication is more than just language and includes nuances, phrases, colloquialisms and body language. A group representing patients highlighted other factors that form part of communication; the ‘physical environment, time of day, and the clothes being worn by the people involved’. They also highlighted the importance of wider communication factors in relation to people with speech and/or hearing problems and the additional support and assistance required. NCAS also said that there has been a move away from knowledge about language per se to ‘communicative competence’ measured through task-based language assessments. We also received some comments relating to strong accents and different vocabulary across the UK. One member of the public commented that they struggled to understand their GP’s strong accent.

One Medical Royal College shared information on areas of work they are undertaking to improve communication - the introduction standards for electronic patient records and communications, and a work programme around a shared decision making approach where clinicians work in partnership with patients, making decisions together to achieve the best outcomes of care.

Some respondents highlighted the fact that IMG doctors were required to undertake the PLAB assessment as well as IELTS and therefore we were not checking the communication skills of EEA doctors in the same way. The PLAB test is the main route by which IMGs demonstrate that they have the necessary skills and knowledge to practise medicine in the UK. PLAB part 2 is an Objective Structured Clinical Examination. It takes the form of 14 clinical scenarios or 'stations'. Doctors may be asked to examine a patient, take a history and give a diagnosis, or to carry out a practical procedure. Broader communication skills are important here.

This consultation is solely focused on English language skills. However, we recognise the importance of communication skills. Good medical practice (2013) sets out clear duties in relation to communicating effectively and working collaboratively with colleagues to maintain and improve patient care, as well as establishing and maintaining partnerships with patients.

One respondent commented extensively on the different standard of training of doctors in different European countries, and provided a range of anecdotal information about their training systems and personal experiences of treatment. The respondent urged the GMC to require these European doctors to undertake
knowledge tests prior to allowing them to work in the UK. The GMC is not legally able to require European doctors to undertake an assessment of their skills and knowledge to practise medicine in the UK.

**Welsh language**

We received a small number of responses highlighting the importance of Welsh language skills for doctors working in areas where the population speak Welsh predominantly. One respondent raised concerns that some Welsh medical students may not have the necessary knowledge of English. We provided information about where the respondent could escalate these concerns. It’s worth noting that under our proposals we will have powers to require any doctor to demonstrate that they have the necessary knowledge of English, prior to granting a licence.

Recent changes to the recognition of professional qualifications Directive (2005/36/EC) clarify that each member state is only able to assess one official language. This does not preclude employers from encouraging professionals to use or learn a second language if this would be beneficial to patients, or refusing employment where Welsh language is a prerequisite for the role.

On the wider issue of communicating with patients in the Welsh language, the GMC does not issue specific guidance to doctors about the use of the Welsh language. However, *Good medical practice* states that in order to communicate effectively, doctors must ‘share with patients, in a way they can understand, the information they want or need to know about their condition, it’s likely progression, and the treatment options available to them, including associated risks and uncertainties’. It also states that doctors must make sure, wherever practical, that arrangements are made to meet patients’ language and communication needs.

**Increase in the IELTS test scores**

Some respondents commented that the current score accepted by the GMC should be increased. We currently require a minimum score of 7 across all four components of the test. We have undertaken research into setting the appropriate IELTS thresholds and plan to implement the outcome of the research later this year.

**Alternatives to IELTS**

Most IMGs demonstrate their knowledge of English using the IELTS test. Currently the academic version of IELTS is the only test that we accept as evidence of knowledge of English. A number of respondents put forward alternative tests to IELTS, such as Cambridge Proficiency and the French Upper Education Ministry accredited exam Certification en Langues de l'Enseignement Supérieur.

The academic version of the IELTS test is widely accepted by employers, regulators and professional bodies as a means of assessing proficiency in English in a professional environment. It is widely available and relatively inexpensive for candidates to undertake. However, we do recognise that alternatives are becoming available, so we review our evidence requirements on a regular basis to ensure they
remain suitable. In 2013, we went out to tender for a research partner to compare the available tests of English proficiency with IELTS.

The research into alternatives to the IELTS test will:

1. Identify available test(s) of English language proficiency and/or communication skills, including those used within a medical context (UK and international)
2. Consider how other professional regulatory bodies (UK and international) check for English language proficiency for entry to a technical, high-risk profession
3. Compare identified tests to IELTS with respect to ‘suitability’
4. If one or more tests are identified as being at least as suitable as IELTS, identify what would be the equivalent in the identified test(s) to the GMC’s current requirements for the academic version of IELTS.

This research will take time to complete but we expect it to conclude during 2014. We will give full consideration to accepting any suitable alternatives to IELTS as soon as we are confident that these methods provide the necessary assurance of a doctor’s English language capability.

Telemedicine

The Medical Royal College of Radiologists highlighted the importance of language skills of doctors who practise remotely on patients through telemedicine.

The provision of telemedicine services raises challenges in relation to the regulation of cross-border healthcare. The GMC is not a regulator of medical services but of medical practitioners. The GMC regulates doctors who are on its register.

However, we do agree that, even though NHS service provision is a devolved matter, it is in the best interests of patients across the UK that all doctors who are delivering telemedicine services meet recognised UK standards of practice. Those who are commissioning telemedicine services from doctors based outside the UK are advised to ensure that doctors are appropriately qualified and regulated. Those non-UK doctors should demonstrate via their regulatory body/competent authority, or through other means, that they are up to date and fit to practise.

Welcome to UK Practice programme

Throughout the consultation, there were a small number of respondents who referred to the helpfulness of induction programs, including shadowing, to help a doctor settle into working in a new environment – especially in a second language. One Local Medical Committee highlighted the importance of overseas trained doctors understanding NHS systems and expectations of doctors in the UK (as set out in Good medical practice) before they begin to practise.
The GMC recognises the challenges doctors face as they transition into practice in the UK. We believe that an induction programme for doctors new to our register can help improve medical practice and, in turn, the quality of care that patients receive.

Working with employers and educators we have been developing the *Welcome to UK Practice programme*. The programme aims to raise awareness of the ethical and professional standards expected of doctors practising in the UK. More information about the *Welcome to UK Practice programme* is available online.
Annex B: events and meetings

We attended a number of meetings during the consultation period. We were not eliciting responses during the meetings, but providing general information about our proposals and encouraging people to respond through our e-consult site. However, we have included a high level summary of themes or discussion points from the meetings.

Overall, these comments reflect the themes already addressed in section 2.

<table>
<thead>
<tr>
<th>Event</th>
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<tbody>
<tr>
<td>UKAF - Scotland</td>
<td>18 September 2013</td>
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<tr>
<td>UKAF – Northern Ireland</td>
<td>19 September 2013</td>
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<tr>
<td>UKAF - Wales</td>
<td>26 September 2013</td>
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<tr>
<td>BMA International Committee</td>
<td>31 October 2013</td>
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<tr>
<td>BME Doctors Forum</td>
<td>24 October 2013</td>
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<tr>
<td>Medical Staffing reference group</td>
<td>11 November 2013</td>
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</table>

**UK Advisory Forums**

The UK Advisory Forums (UKAF) support the Council’s role in ensuring that we have effective engagement with key interest groups, and that our policies are suited to the UK context. Each Forum considered a paper setting out our proposals. Key points raised in discussion were:

- overall agreement with the need to fill this regulatory gap and the proposals set out in our consultation document.
- broader comments on the term ‘knowledge of English’, including the need for it to include understanding and being understood, rather than just fluency.
- agreement that there will be limited impact on medical students from Northern Ireland who have completed their Primary Medical Qualification in the Republic of Ireland.
- whether the IELTS test is satisfactory
- the GMC’s review of the PLAB test is looking at ways to measure communication more effectively.

**BMA International Committee**

The BMA's International Committee includes representatives of all the main branches of practice, and discusses European and international issues of interest to the medical profession. We presented our proposals to the BMA International Committee and the following themes arose out of the discussion.

- The need to ensure that what we are proposing is proportionate to what we are trying to achieve. In relation to the first half of the consultation, this included concerns around the types of evidence and whether it would apply to doctors treating their own nationals in the UK or doctors without patients. We
highlighted the need for doctors to be able to communicate effectively in English in any UK medical environment.

- The new ground of impairment and the overlap with lack of insight or poor communication skills, as well as fairness and access to remediation. We explained how cases are often multi-faceted, and in terms of language, the easiest way to address this is through an assessment. We will encourage doctors to take steps to improve their language skills voluntarily, but we may consider a referral to a fitness to practise panel if a doctor refuses or does not improve sufficiently. Panels have a range of proportionate options available to them, such as putting limits on a doctor’s registration until their language has improved.

- The IELTS test. The group queried our relationship with IELTS providers, and whether we are satisfied that it is an appropriate test. We explained that IELTS is a commonly accepted test across a range of employers, regulators and professional bodies as a means of assessing English language skills. However we are commissioning research to identify if other tests are also suitable. The group asked us to consider providing links to good quality language providers, and we agreed to consider this. They also queried the fairness of requiring doctors to pay the cost of a language test as part of a fitness to practise investigation. We have responded to this question in annex A of this document.

- The interaction between these proposals and revalidation. We explained that, as part of making revalidation recommendations, responsible officers needed to be assured of the doctor’s fitness to practise – and this includes language skills. We responded to this question in annex A of this document.

The BMA provided a response to our consultation and the key themes from their response are set out in annex A.

**Black and Minority Ethnic Doctors Forum**

The purpose of the BME Doctors Forum is to raise issues of interest to its members with the GMC. It also acts as a sounding board to help the GMC to understand the issues that affect BME doctors and IMGs, and in so doing, helps to shape the development of the GMC’s plans and activities.

We presented our proposals to the forum and encouraged members to respond to the consultation. There was a short discussion following the presentation, raising the following themes:

- not all patients speak English
- disability considerations, particularly the use of British Sign language
- the IELTS test
- the same system should be in place for IMGs and EEA doctors.
Medical staffing reference group

We run a Medical staffing reference group with a small group of medical staffing managers and human resource directors, as well as representatives from the National Association of Medical Personnel Specialists. We took this opportunity to present to the group on our proposals. While not directly affected by our proposals, we received a range of helpful comments during some round-table discussions.

- Overall support for all of the proposals.
- In relation to question 6, they felt that 90 days should be the maximum amount of time that doctors should have to comply with a direction to undertake a language assessment, as part of a fitness to practise investigation as this balances the need to prepare for the assessment with the easy availability and accessibility of the assessment.

- They felt this would be a positive thing for employers because it would strengthen the ability of employers to manage language concerns. They admitted that communication issues are considered more difficult to address than competency, and currently employer language checks are patchy and there is a feeling that they cannot do anything about European doctors. They also raised the need for the issue to be consistently communicated across all specialties, and what it means for recruiters and managers.

- Some questioned whether there was an end point to ‘indefinite suspension’ and the impact this might have on payroll and recruitment.

- IELTS and the difference between communicating medically rather than in good English.
Annex C: GMC News

We featured an article on ‘New powers to check doctors’ language skills’ in the October version of our monthly e-bulletin for all registered doctors, GMC News. The article explained the proposed policy and included links to both our consultation and the Department of Health’s.

We encouraged doctors to respond to the consultation and to post their thoughts on the policy through the on line comments facility. 299 responses were posted under this article which is the highest number ever received for any topic appearing in GMC News.

As respondents were giving their personal views on the proposed policy and not responding to a particular question the comments received covered many different areas and personal experiences. In reviewing these comments a number of key themes emerged which are covered in the sections below. Our responses to these issues and themes are contained within annex A of this report and therefore are not repeated here.

Overall feedback

The overwhelming majority of responses expressed support for the principle of the GMC having powers to check the language skills of doctors practising in the UK and particularly to bring the requirements for European doctors in line with IMGs. It was considered that such a move would enhance the standard of medical care in the UK and improve patient safety.

Assessing language skills or communication skills

Respondents were unanimous in their opinion that good English language skills are essential for patient safety and effective team working. Many were explicit that assessing reading, writing and effective listening skills are as important as the ability to speak English fluently.

Reflecting answers to questions in the main consultation about types of evidence we will require, comments on GMC News also focussed on whether the academic version of IELTS is the appropriate method to assess the language skills of European doctors seeking GMC registration. Many indicated support for the test as an objective and verifiable method. A number of GPs who qualified overseas provided their first hand experiences of having to pass the academic version of IELTS in order to gain entry onto the Performers List. These respondents felt that the same minimum standard of English should be required from all overseas doctors practising in the UK.

Other respondents highlighted that the assessment should be more than meeting a minimum standard of speaking and understanding English. This extended the discussion into a whether the proposed policy should be dealing with an assessment of wider communication skills issues rather than solely language skills. A common view was that language skills do not equal good communication skills, with some
comments referring to native English speaking doctors failing to communicate well. A high number of respondents emphasised the importance of the subtleties of communication such as understanding phrasal verbs; metaphors; colloquialisms; local dialects; and body language as key areas for all doctors to be aware of, especially when interacting with patients.

Several doctors expressed the opinion that any language assessment should be related to clinical practice and medical terminology rather than an assessment of general English. However this was outweighed by those who emphasised that doctors working in the UK have to deal with colleagues and patients whose command of English may vary, and therefore a test of general English is more appropriate.

**Scope of language checking**

As referred to above, many respondents expressed support for the proposal that all European doctors should have to meet the same minimum standards required from International Medical Graduates. Going further, a large number favoured the introduction of universal language assessment for all overseas doctors coming to work in the UK.

This view was countered by respondents who suggested that a proportionate approach would be to exempt overseas doctors who meet the following criteria:
- educated in English
- from a country where English is the native language
- doctors who have sat Royal College exams that includes an assessment of English

In addition to the above, a small number of respondents thought that there should be exceptional circumstances where a doctor should not be required to demonstrate their English language capability e.g. doctors applying for GMC registration who will be employed by private companies to treat nationals of their own country, or doctors in areas of practice with limited patient interaction.

Exemptions on these grounds were discounted by other respondents who argued that language assessment should apply to all doctors because of the need to interact in English with professional colleagues, regardless of the doctor’s level of patient contact. On this issue, there were references to personal experiences of poor written English leading to confusing information on patient notes.

**Dealing with the language skills of registered doctors**

While the vast majority of comments focused on the introduction of language assessment for European doctors seeking a licence to practise, two respondents did make specific reference to dealing with registered doctors with poor language skills. These comments suggested that the respondents had either not read or had not understood our proposals, as one questioned how we would deal with registered
doctors, and the second suggested that registered doctors should be given the opportunity to improve their English before we took any action against them.

**Objections to the proposed policy**

Two respondents wholly objected to the introduction of language checking of European doctors. The first objection was on the grounds that the GMC should remain in line with EU legislation and the second that the GMC should not be given more powers over doctors.

Several others comments did not think the GMC was the appropriate body to make this assessment and recommended that employers should have responsibility for language checks at interview (before employing a doctor) or that an assessment of language took place through the revalidation process (for employed doctors).

Other respondents expressed support for the principle of language checks but raised concerns relating to introducing additional bureaucracy into the application process and the potential for knock on consequences such as complaints about doctors with strong accents or poor communication skills, neither of which are to do with English language capability.

**Additional issues**

In common with responses to the main consultation questions, respondents on GMC News chose to link the introduction of language checks to several other issues including:

- dissatisfaction with the two year validity of an IELTS certificate
- a PLAB type examination, including an English exam for all doctors seeking to practise in the UK
- the GMC should work with other regulatory bodies to introduce language checks for all UK health care staff
- language checks should be applied to competency in Welsh.
Annex D: organisations that responded to the consultation

Academy of Medical Royal Colleges
Action Foundation
British Medical Association
Cambridgeshire Local Medical Committee
DRC Locums Group
Epsom and St Helier UH NHS Trust
Faculty of Forensic and Legal Medicine
Health Education England
Health Education North Central and East London
Health Education South London
Health Education South West
Independent Doctors Federation
Independent Healthcare Advisory Services
Independent healthcare provider – Poland Medical
Medical Defence Union
Medical Schools Council
Medical Women’s Federation
NCAS (an operating division of NHS LA)
NHS Employers
NHS European Office
Nursing and Midwifery Council
Professional Standards Authority
Recruitment and Employment Confederation
Royal College of Paediatrics and Child Health
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians of Edinburgh
Royal College of Physicians, London
Royal College of Radiologists
Royal College of Surgeons patient liaison group
The Royal College of Anaesthetists
The Royal College of Psychiatrists
The Royal College of Surgeons of Edinburgh
Royal Free London NHS Foundation Trust
The Scottish Government
University of Bath
Welsh Language Medical Society
Audit Report
ACKNOWLEDGEMENT

The Social Research Centre wishes to thank the General Medical Council’s personnel from the Registration and Revalidation Directorate and the Fitness to Practice Directorate respectively for all their helpfulness during our conduct of this audit.
DISCLAIMER

This report has been prepared for and only for the General Medical Council (GMC) in accordance with the terms of reference specified to Social Research Centre’s (SRC) in January 2014 and for no other purpose.

The opinions expressed by the participants in this consultation are strictly those of the person who gave them and not SRC.

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1. EXECUTIVE SUMMARY

1.1 BACKGROUND TO THE AUDIT

This report is an independent audit, prepared by the Social Research Centre (SRC) (www.srcentre.co.uk) of the consultation data submitted and gathered in relation to the General Medical Council’s (GMC) consultation on, “Making sure that all licensed doctors have the necessary knowledge of English to practice safely in the UK” (September to December 2013).

1.2 TERMS OF REFERENCE

This audit was commissioned to provide:

- Reassurance, to both internal and external audiences, about the reliability of the consultation report as an accurate summary of the consultation responses; and,
- An objective confirmation that GMC has identified all of the key themes raised by respondents.

1.3 WHAT WE DID

SRC agreed the priority data sets for examination with GMC and agreed a sampling and audit approach that, within the budgetary and time constraints set for this exercise, enabled us to test the extent to which the data, findings, conclusions, recommendations generated by SRC concurred with those generated by the GMC Analysis Team in terms of completeness, accuracy and substance. In addition, as the audit proceeded, we fed back to GMC where we found differences between GMC’s analysis and our own.

1.4 WHAT WE FOUND

SRC’s audit of the data found that:

- There were very high levels of completeness and accuracy throughout the data sets examined with virtually all of the substantive points included; and,
- In so far as SRC can judge virtually all of the substantive points from the quantitative and qualitative analysis have been identified and considered appropriately in the GMC Analysis Team’s reports.

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1 Source: GMC's Audit Brief to SRC – January 2014.
2 i.e. Based on an examination of the available data alone (and no other considerations)
Please Note: As the audit proceeded, we brought GMC’s attention to a small number of differences in our analysis vs GMC’s. We would stress that these points were presentational rather than material. Notwithstanding this, GMC did respond to these and SRC is satisfied that these points have now been reflected in GMC’s consultation report.

Whilst not part of our formal terms of reference, we have, for the purposes of continuous improvement, provided GMC with a short list of general points upon which GMC may wish to reflect regarding the analysis of data in future consultations. At the time of writing, we were given to understand that GMC has committed to sharing these points with other colleagues involved in consultation exercises.
2. INTRODUCTION AND BACKGROUND

2.1 BACKGROUND TO THE CONSULTATION

2.1.1 Role of the General Medical Council

The General Medical Council (GMC) registers and licenses doctors to practise medicine in the UK.

2.1.2 Background to the Consultation

Currently, all international medical graduates (IMGs) must demonstrate to the GMC that they have the necessary knowledge of English before they can practise as doctors in the UK. The GMC only grants registration with a licence to practise if they can do so. However, the law currently prevents the GMC from seeking evidence about the English language skills of European doctors.

In February 2013, the UK Government announced plans to give the GMC new powers to ensure that all doctors working in the UK have the necessary knowledge of English to practise safely. The Department of Health (England) undertook a consultation on proposed changes to the Medical Act 1983 (the Act) from 7 September to 2 December 2013. Changes to the Act proposed by the Department cover two key areas:

- to enable the GMC to ask European doctors for evidence of their English language skills where they have concerns about their ability to communicate effectively, before they grant a licence to practise; and,

- to strengthen the GMC’s ability to take action in relation to doctors who are already licensed where concerns are raised about their language skills.

To implement these changes, the GMC proposed amendments to four pieces of legislation. They consulted on these proposals from 17 September to 10 December 2013.

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3 The description of the background to, the operation of, the responses from and the analysis of the consultation process was provided by GMC.
4 For the purposes of this document, an IMG is a doctor who is not a UK graduate or a European Doctor.
5 In this document, the term ‘European doctor’ refers to a doctor who is:
   • a national of a relevant European state (this means a national of a member state of the European Economic Area or Switzerland), or
   • not a national of a relevant European state, but is entitled to be treated no less favourably for these purposes because he or she benefits under the Citizenship Directive from an enforceable Community right.
2.2 **THE CONSULTATION PROCESS**

2.2.1 **Launch**

The consultation was launched on 17 September 2013 and ran for 12 weeks. It closed on 10 December 2013. One respondent (the Professional Standards Authority) requested an extension and the response arrived after the closing date.

2.2.2 **Publicising the Consultation**

A range of methods were used to publicise the consultation and ensure a range of audiences were aware of it:

- It was prominent on GMC’s website;
- Supported the consultation with an online GMC News article which is emailed to all doctors who were signed up to receive GMC News to invite their response (over 10,000 opened the webpage);
- Directly emailed over 400 relevant organisations, including charities, organisations representing doctors, medical defence unions, regulators, European medical organisations, EU institutions and stakeholders from the four UK countries to notify them of its launch and to invite responses; and,
- Published a Welsh language version of the consultation document.

2.2.3 **Consultation Questions**

The GMC asked eight questions about the proposed changes to the rules and regulations as follows:

- **Question 1:** Do you think it is fair and proportionate to require the same evidence of English language capability from European doctors as international medical graduates?
- **Question 2:** Do you agree that we should not grant a licence to practise to a European doctor when they have been unable or unwilling to show they have the necessary knowledge English to work safely in the UK?
- **Question 3:** Do you agree that it is fair and proportionate to be able to ask doctors who have no responsible officer or suitable person to demonstrate they have the necessary knowledge of English where we have a concern, as part of their revalidation?
- **Question 4:** Do you agree that if there is a serious concern about a registered doctor’s knowledge of English, we should have the power to require a doctor to undergo a language assessment?
- **Question 5:** Do you agree doctors should pay the cost of a language assessment where there is a relevant fitness to practise concern?

- **Question 6:** Do you agree that 90 days is a reasonable time period for doctors to comply with a direction to undertake a language assessment?

- **Question 7:** Do you agree that we should be able to indefinitely suspend doctors who fail over time to acquire the necessary knowledge of English to safely treat patients in the UK?

- **Question 8:** Do you agree that we should be able to ask doctors to undergo a language assessment when they apply to be restored to the register if there is a concern about their language skills?

Respondents were asked whether they agreed or disagreed with each question, and had the option of stating that they were not sure.

Respondents were then asked to provide any additional comments, especially if they answered no or not sure.

All of the responses were optional.
2.2.4 Submitting Responses

The consultation provided a number of ways in which respondents could submit their views:

- **Structured responses** - There were two types of these:
  - E-consult responses: The vast majority of the responses (n=232) were submitted via GMC’s e-consult web site.
  - ‘Response Form’ responses: Rather than use the e-consult system, some respondents (n=37) opted to complete their response by filling out a downloadable pdf (‘response form’ 6) and then emailing this to GMC 7. The response form had the same format as the questionnaire on GMC’s e-consult system.

- **Unstructured written responses** - Some respondents did not complete the consultation questionnaire but instead sent a variety of comments to GMC via email or letters. These responses were entered into a separate log and analysed and reported on along with the free text comments in the e-consult site and on the response forms.

- **Meetings** - During the consultation period, GMC staff met with key stakeholders / bodies representing doctors. Some of these meetings were facilitated/hosted by the GMC and some by external organisations. The main purpose of these meetings however was to encourage people to respond to the consultation. Notwithstanding this, some comments about the consultation were noted and analysed as part of the exercise.

- **GMC News Links** - The GMC publicised their consultation using an online newsletter called ‘GMC News’. Actual number 299 8 people used this channel to submit an online comment after the news story.

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6 Note: GMC also published a Welsh language version of both the consultation document and response form.
7 Note: The responses from those who emailed GMC using a pdf response format were also uploaded onto the e-consult site. However, ‘Yes’, ‘No’, ‘Not sure’ responses were only entered where the respondent had made clear which response they had selected.
8 GMC explained (in an email from GMC 24 January 2014 14:05) that whilst the GMC website stated that there were 285 responses, GMC Consultation report actually states there were 299. This is because GMC has a policy not to publish responses online where (a) The person does not provide a name or (b) the person has provided personal information about their own circumstances (for example, they refer to a personal circumstance and ask a query or advice on what to do). There were 14 responses to which criteria (a) or (b) applied and hence the apparent discrepancy in the numbers. However, GMC analysed all of the responses submitted.
2.2.5 **Context: Other Concurrent Factors**

Whilst no other GMC consultations were running at the same time as this consultation, it is worth noting that the Department of Health (DoH) (England)’s consultation on their proposed changes to the Medical Act 1983 – ‘Ensuring doctors have sufficient English language capability’ - started one week before and finished one week earlier than GMC’s. In effect, these two consultations (which both sought views on knowledge of English) ran in parallel for most of the time.

It is possible that some people responded only to the DoH consultation (which covered the more high level principles behind these changes) rather than commenting on the detail required by GMC’s consultation.

For information, the Department received 54 responses; GMC received 302.

2.2.6 **Analysis of the Consultation Responses and Next Steps**

All data collected throughout the consultation process was collated and analysed by GMC between mid-December 2013 and mid-January 2014.

The report contains a summary of the consultation responses - what respondents said. They do not discuss whether the GMC will make any changes to their draft legislation based on the consultation responses. The GMC will consider the responses, as summarised by the consultation report, and use that information to decide whether any changes to their draft legislation are necessary. Any changes identified will be agreed by the GMC’s Senior Management Team, and approval will be sought from the GMC’s Council in the form of a paper to Council with recommendations.

The GMC is in the process of drafting guidance to accompany these changes. Feedback from the consultation will be taken into account in drafting this guidance.

2.3 **TERMS OF REFERENCE FOR THE AUDIT**

The terms of reference of the audit specified that:

- The **purpose** of the audit was twofold to provide:
  - **Reassurance**, to both internal and external audiences, about the reliability of the consultation report as an accurate summary of the consultation responses; and,
  - **An objective confirmation** that GMC has identified all of the key themes raised by respondents by considering whether the analysis reports the team produced reflected a **fair and reasonable interpretation** of the consultation data.

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9 This includes e-consult, offline responses and free format responses.
10 Source: GMC’s Audit Brief to SRC – January 2014.
The scope of the audit was to evaluate the following:

- **Preparation of data for analysis** (including the transfer of unstructured responses into the structured questionnaire and the accuracy of replicating responses onto the database); and

- **Interpretation of results** (qualitative and quantitative data);

Consequently, the crucial test within this audit was the extent to which the data, findings, conclusions, which SRC generated, concurred with those of the GMC Analysis Team in terms of completeness, accuracy and substance.

### 2.4 SCALE OF THE AUDIT

GMC commissioned SRC to invest a small number of days on the design and conduct of this audit of the consultation responses including this report on its findings.
3. **WHAT WE DID**

3.1 **OVERVIEW**

This section details how each phase of the audit was conducted.

3.2 **A PRINCIPLES-BASED APPROACH**

Our conduct of the audit was founded on the following six principles:

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RISK</strong></td>
<td>Assessing where the greatest risks lay in terms of any potential for the data to be altered or misinterpreted in any way, and then and focusing attention specifically on the higher risk areas.</td>
</tr>
<tr>
<td><strong>SALIENCE</strong></td>
<td>Allowing the shape and emphasis within our audit to be informed by an understanding of the aspects of the consultation which were perceived to have special strategic significance for GMC.</td>
</tr>
<tr>
<td><strong>ACCURACY</strong></td>
<td>Designing and deploying specific measures to check the extent to which the response has been correctly assigned to the appropriate section of the consultation in accordance with the analysis instructions.</td>
</tr>
<tr>
<td><strong>COMPLETENESS</strong></td>
<td>Designing and deploying specific approaches to test the extent to which all information submitted had been included in the analysis.</td>
</tr>
<tr>
<td><strong>SUBSTANCE</strong></td>
<td>Confirming, to the fullest possible extent, within the time and budgetary constraints of this exercise, that all material issues had been identified and considered.</td>
</tr>
<tr>
<td><strong>SAMPLING</strong></td>
<td>Judicious sampling of key data sets to perform the above tests and checks. Note, within this audit, SRC sampled data both ‘vertically’ i.e. looking at how complete and accurate individual responses were (Data Sets 1 and 2 below) and ‘horizontally’ i.e. examining the interpretation of specific segments of data in relation to specific questions.</td>
</tr>
</tbody>
</table>
3.3 INITIAL RISK ASSESSMENT & SPECIFIC AUDIT MEASURES DEPLOYED

3.3.1 Initial Risk Assessment

At SRC’s initial discussion with the GMC Analysis Team\(^\text{11}\) on 9th January 2014, the following data sets were identified and the risks associated with each were agreed. As the description below explains, this mutual assessment of risk directed SRC in terms of where to invest its efforts across the audit exercise.

Essentially, the risks associated with each data set, and the choice of specific audit measures to consequently deploy, were assessed in two ways, namely by examining:

- ‘Vertical’ data sets i.e. looking ‘down’ the data i.e. to assess the likelihood of the specific types of data being entered completely and accurately; and,

- ‘Horizontal’ data sets i.e. looking ‘across’ the data. This involved collective consideration of different sets of data each of which could potentially to a range of questions within the consultation. Our goal was to assess the likelihood that the issues and themes therein had been identified completely and accurately.

The details of our risk assessments are set out below in Section 3.4.

Overall, our assessment found that the majority of the data sets were \textit{LOW RISK} i.e. the specific way(s) in which data was captured intrinsically protected the completeness and accuracy of the data such that the possibility of corruption / inaccuracy was very low or negligible. With only one exception (see below), the data sets that were deemed to be \textit{NO RISK} or \textit{LOW RISK} were not audited.

In contrast, the analysis of the many open ended comments in the questionnaire responses and the unstructured responses by email and letter were, inherently, more complex and consequently vulnerable to a degree of interpretation. For this reason we mutually agreed with GMC that these types of data should be classified as \textit{MEDIUM RISK}.

3.3.2 VERTICAL DATA SETS - ‘LOOKING DOWN’ THE DATA

\textbf{Data Set 1: On Line Questionnaire Responses}

The vast majority of the structured responses to the consultation questions (232 out of 269) were submitted online directly by respondents on the GMC e-consult site \url{https://gmc.e-consultation.net/econsult/default.aspx}. Respondents were asked to select ‘yes’, ‘no’ or ‘not sure’ to eight questions. At each question, they had the option to provide additional free text comments.

In terms of ‘risk’ (i.e. perceived degree of threat to accuracy and completeness of the data) the \textit{online responses} were considered to be \textit{NO RISK} because the data had

\(^{11}\) Note: The ‘GMC Analysis Team’ for this consultation exercise was comprised of staff from the Registration and Revalidation Directorate and staff from the Fitness to Practice Directorate.
been entered directly by the respondent into a secure system and no interference with the data entered was possible. Hence, we did not audit this data in terms of its being entered completely and accurately since it was assumed to be complete and accurate by virtue of the data capture mechanism. However, in agreement with GMC, we selected two questions to audit in detail (Question 1 and Question 5). These questions were considered to be fundamental in terms of the consultation overall and, consequently merited detailed examination in terms of arithmetic accuracy and identification of key themes. (See Section 3.3.x below – Sampling Approach)

**Data Set 2: Response Forms - Writeable PDF versions of the Online Questionnaire**

GMC produced a ‘writeable’ pdf version of the questionnaire that respondents could use to enter their responses and then submit to GMC via email. GMC then entered all these electronic responses into the e-consult system by copying and pasting data into the relevant fields.

Some respondents did not use the template form, but their response still followed the question by question format. In these cases, GMC loaded the responses into the e-consult site in the same manner.

One response was written by hand and GMC typed this directly into the e-consult site.

GMC received 37 ‘response forms’ and there is a small risk that GMC transposed some information incorrectly. However, it can reasonably be assumed to be complete and accurate by virtue of the data capture mechanism (i.e. all (n=37) were submitted electronically) plus the ‘mechanical’ nature of a cut and paste routine. For this reason, we opted to select 5 examples at random because there was some (albeit very small) potential for data to be corrupted as it was cut and pasted between systems.

For these reasons, we classified ‘response forms’ as **LOW RISK**.

**3.3.3 Horizional Data Sets - ‘Looking Across’ the Data**

**Data Set 3: Free Format Written Responses - Emails / Letters - Non-Standardised**

GMC received 34 responses (in the form of letters and emails) that did not follow the format of the consultation questionnaire. Whilst these submissions varied in type and length (see below), the nature of the risk, in terms of completeness and accuracy of data capture, was similar for each in that GMC needed to exercise judgement to decide:

- what to enter into the main database (e.g. in relation to a specific consultation question); and,
- under what theme(s) to classify the response.

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12 One was a duplicate (which would have taken the total number of responses to 38. However, since it was clear it was a duplicate it was only counted once – hence 37.

13 Note: GMC advised that only those that followed the structured format of the questions were uploaded and included in the 37 in Data set 2.
The main forms of ‘non-standardised’ response were:

- Emails/attachments commenting on the questions, paragraphs or both but not necessarily in the specified order and with varying levels of compliance in terms of what they have included; and,

- Emails/attachments which did not specifically mention questions (i.e. paragraphs of prose only).

In all of these cases, two experienced individuals within GMC were assigned specific responsibility for reviewing and dealing with these responses. These individuals analysed these responses in a manner consistent with previous GMC consultations. This analysis was also reviewed by another GMC colleague in relation to questions 4 to 8. Notwithstanding these safeguards, it was deemed that, given the inherent diversity and potential complexity of these submissions, that the level of risk was MEDIUM. Hence, we audited a small (n=8) random sample of these submissions for completeness and accuracy.

**Data Set 4: Meetings / Group Discussions**

GMC did not host particular meetings / group discussions to seek feedback on the consultation. Instead, a small number (n=6) of meetings were attended by GMC staff where GMC presented its proposals on the consultation. It is important to note that the sole purpose of this was to motivate potential respondents to respond to the consultation NOT to collect responses to the consultation per se. Indeed, we were given to understand that the discussions at the meeting did not follow the structured questions in the consultation. 14. We were also given to understand that some of these meetings did not have formal minutes. However, for completeness, GMC did review all of the formal minutes that were available and also reviewed notes taken at each of the meetings.

Following the meeting with the BMA, the BMA provided a formal consultation response (which was already analysed as part of data set 2).

Overall this data set was ranked as LOW RISK.

**Data Set 5: GMC News Links**

In 2 October 2013 GMC’s Communications colleagues published a brief article in GMC’s online newsletter. This is issued to all doctors. The original intention of the article was to encourage doctors to respond, in a structured manner, through GMC’s e-consult site. However, many responded directly by leaving an e-comment on the GMC website or sending a brief email to GMC’s publications email address.

14 Note: The BMA used the meeting to seek an overview of the consultation and to seek clarification. They then used the information to inform their formal response which they submitted following the meeting. This was considered in Data Set 2 above.
The facility to ‘leave a comment’ was open from 2 October 2013. GMC advised (20th January 2014) that there had been no new comments for over a month (i.e. since December 2013).

Since the overwhelming majority of the information submitted in response to the article was via e-comments (i.e. 299 e-comments vs 40 emails) and respondents provided these comments directly online themselves, there is **NO RISK** that the accuracy or completeness of data could be affected.

Whilst large in number (299 e-comments) the value of this data set in the context of the consultation is constrained by the fact that:

- It is not clear whether the respondent is / is not responding with knowledge of the content of the consultation documents;
- The format of the e-comment did not - and was not required to - follow the format of the structured consultation questionnaire;
- The e-comments in each case are very brief – typically a sentence or two;
- Unless the person identified themselves in their e-comment or email, they cannot be identified and therefore GMC cannot say, overall, how representative the feedback is;
- Many of the entries are ‘commenting on comments’, much like on a website or blog, rather than being distinct unique entries pertaining to the specific consultation questions.

### 3.3.4 Sampling Approach and Analysis Framework Agreed

**In summary, the way in which SRC analysed and interpreted the data within the audit was as follows:**

- **Step 1: Analyse and Interpret** - In this Step, we created an Analysis Framework (see our description of the treatment of each data set below). This enabled SRC to take a sample of data from each of the data collection processes and then independently analyse it to assess the extent to which our findings, conclusions and recommendations (both quantitatively and qualitatively) concurred with the analysis performed by GMC. Crucially, we produced our analysis by:
  - working directly with the primary data as far as possible (and with summaries in only a small number of cases); and,
  - without reference to the GMC Analysis Team’s own workings.

- **Step 2: Compare** - When we had completed our own independent analysis and interpretation, we then compared this with the GMC’s Team’s own analysis. The findings from our comparison are summarised in Section 415).

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Note: All relevant working papers have been provided to GMC.
The reader should note that whilst it was feasible and appropriate to compare the quantitative data from a strictly arithmetic perspective, qualitative data, by its very nature requires a different approach. Within the time and budgetary constraints available for this audit, SRC’s approach to analysing the qualitative data was to compare on ‘substance’ and ‘reasonableness’. This involved:

- Identifying the distinctive points emerging from selected segments of questionnaire data analysis (e.g. analysis of comments of those who said ‘Yes’; those who ‘said ‘No’ and those who were ‘Not Sure’ in relation to question 1 and 5 only);

- Checking that the key issues identified in the other data sets sampled had been reflected appropriately in GMC’s overall analysis; and,

- Comparing all of this with the GMC Analysis Team’s own work to ascertain if there were any material differences between our findings and theirs.

The reader should note that SRC is entirely open about the fact that its capacity to interpret the data and make recommendations based on it is heavily constrained. We did not, nor were we expected to, possess the level of specialist and contextual knowledge of the GMC Analysis Team. Consequently, our interpretation of the material is based only on a broad comparison of the distinctive points emerging from the data available for analysis and not on wider contextual knowledge or understanding of the full authority of and constraints upon GMC, legislatively, financially or otherwise.

Given both of these factors, SRC’s approach to auditing the GMC Team’s Analysis was to create a summary of our own of all of the distinctive points that had emerged.

We then compared this with the points made by the GMC Analysis Team in the various sections of its report.

Given the scale and complexity of the data that had been collected, and the limited time and budgetary constraints available for the audit exercise, GMC and SRC mutually agreed that a sampling approach was the only feasible way forward.

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16 Note: In relation to the questionnaire data, SRC audited the overall count of the responses by option i.e. ‘Yes’, ‘No’, ‘Not Sure’, Blank’ and ‘Total’ on a randomised basis. We also audited the percentages and number of comments cited in relation to each of the options. Again, on a randomised basis, SRC audited GMC’s breakdown of the responses by source i.e. organisation / individual. The rationale behind a randomised approach rather than slavishly and exhaustively auditing each set of responses in full was three-fold (a) the process for analysing this data is straightforward and is unambiguous in the results it produces; (b) same process was used to analyse each type of data above (either ‘by option’ or ‘source’) and hence the likelihood of consistently producing complete and accurate results was very high; and, (c) operating this strategy enabled SRC to invest more time and effort in auditing the more complex, higher risk data sets including qualitative data.

17 Given the budgetary and time constraints on this exercise, SRC determined that this was the only feasible approach to take. More detailed analysis by ‘themes’ and ‘mentions’ and / or detailed coding and quantification of the qualitative responses was not achievable within the limited specified for this exercise and indeed any such comparison would have involved pre-agreement with GMC on what the specific themes were (i.e. so as coding frames could be set up).
Audit Sample of Data Sets 1 and 2 i.e. Individual Questions

The complete and correct interpretation of the data pertaining to specific questions was at the heart of the consultation and, consequently, was the major focus of this audit process.

Whilst one option would have been for SRC to simply choose two questions at random to analyse in details, we rejected this (GMC agreed) on the basis that such an approach might not select areas for examination that the GMC Analysis Team considered to be the most pertinent and / or valuable in the context of an audit. Hence, an important opportunity to provide assurance and potentially rigour would have been missed.

Consequently, in order to ensure that SRC’s audit work would be invested in examining aspects that the GMC Analysis Team considered the most valuable, we invited the Team to specify two areas that they considered to be especially salient in the consultation overall. Whilst several areas were potential candidates, the two areas finally selected were:

- QUESTION 1: Do you think it is fair and proportionate to require the same evidence of English language capability from European doctors as international medical graduates?
- QUESTION 5: Do you agree doctors should pay the cost of a language assessment where there is a relevant fitness to practise concern?

It was also agreed that within the budgetary and timescale constraints of the audit, that SRC would only audit the ‘Yes’ ‘No’ re Q1 and ‘Yes’, ‘No’ and ‘Not Sure’ responses re Q5 and not the ‘blanks’ in relation to either Q1 or Q5 respectively.

Audit Sample of Data Set 3: Free Format Written Responses - Emails / Letters - Non-Standardised

Following discussions with GMC, it was agreed that the most useful sample of the free format responses, within the context of the audit, would be the responses submitted by organisations representing doctors (i.e. rather than the responses from individuals). The rationale for this was that such responses were potentially more authoritative – coming from organisations, rather than individuals – and, as membership bodies, represented a much more diverse range of opinion (i.e. an organisation response representing many interests versus an individual submission).

The responses examined submitted by organisations representing doctors were from:

- Royal College of Radiologists;
- Faculty of Forensic and Legal Medicine;
- Scottish Government;

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18 At a meeting with SRC on 9th January 2014, GMC indicated that the answers to these two questions were important to the ‘Fitness to Practice’ and ‘Regulation and Registration’ Directorates respectively. Hence, the rationale for specifically auditing the feedback on these matters.
 Royal College of Physicians – both parts a Letter and later email;
 Welsh Language Medical Society;
 Medical Defence Union; and,
 Professional Standards Authority.

In the context of the audit, SRC sought to assess:

 Completeness – the extent to which all of the response considered;
 Accuracy of analysis – in terms of assignment of the various aspects of the submission to the most appropriate consultation question; and,
 Completeness and accuracy of the identification of any additional relevant themes / issues raised by the respondent.

**Auditing a Sample of Data Set 4: Meetings / Group Discussions**

SRC was given to understand that GMC attended 6 meetings with key stakeholder groups during the consultation period. SRC selected two of these meetings at random for evaluation within the audit. These were:

 British Medical Association; and,
 Black and Minority Ethnic (BME) Forum Meeting.

In the context of the audit, SRC sought to assess:

 Completeness – the extent to which all of the notes from the meeting had been considered;
 Accuracy of analysis – in terms of assignment of the various points raised in the notes had been assigned to the most appropriate consultation question; and,
 Completeness and accuracy of the identification of any additional relevant themes / issues raised at the meeting.

**Data Set 5: GMC News Links**

SRC selected 20 (circa 5%) of these at random.

In the context of the audit, SRC identified the key theme / issues raised by the sample of respondents. We then assessed the extent to which these were reflected in GMC’s analysis set out in Annex C of the GMC Consultation Report and in said report overall.
4. WHAT WE FOUND

4.1 OVERVIEW

This section itemises the key findings, conclusions that ensued from SRC’s examination of the data.

- Overall, the audit had found that the GMC Analysis Team’s approach to analysis and interpretation was highly thorough;
- There were very high levels of completeness and accuracy throughout the data sets examined with virtually all substantive points included; and,
- In so far as SRC can judge, the correct interpretation has been applied to all of the points raised.

The Sections below summarise the key findings and conclusions that ensued from SRC’s examination of the data. ¹⁹

¹⁹ Note: All relevant working papers have been passed onto GMC.
4.2 FINDINGS FROM ANALYSIS OF DATA SET 2: ‘RESPONSE FORMS’

There following tables show the virtually complete levels of completeness and accuracy regarding data entry.

We initially checked the quality of the data entry by checking the completeness and accuracy of a sample of Data Set 5, the writeable pdf versions of the online questionnaire. We found the data entered to be 100% accurate and complete.

<table>
<thead>
<tr>
<th>Data Set</th>
<th>Audit Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Set 2: ‘Response Forms’ Writeable PDF versions of the Online Questionnaires (n=5)</td>
<td>☑ Absolute completeness (100%) and accuracy (100%)</td>
</tr>
</tbody>
</table>

4.3 FINDINGS FROM ANALYSIS OF DATA SET 1: (RAW DATA) WHICH INCLUDED DATA SET 2

4.3.1 Arithmetic Checks

We then analysed the data pertaining to questions 1 and 5 (i.e. Data sets 1 & 2 combined).

The summary tables below evidence the perfect arithmetic match between the number and classification of responses computed by the GMC Team compared with SRC.

<table>
<thead>
<tr>
<th>Question 1: Do you think it is fair and proportionate to require the same evidence of English language capability from E doctors as international medical graduates?</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Blank</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMC results (to nearest %)</td>
<td>244</td>
<td>16</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>SRC results</td>
<td>244</td>
<td>16</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

Degree of match

☑ 100% ☑ 100% ☑ 100% ☑ 1
4.3.2 Key Themes Identified

We took each of the qualitative responses to Question 1 and 5 in turn and we compared SRC’s analysis of the themes identified the analysis performed by GMC (i.e. as documented in Annex A: Question by Question Analysis). In every case, SRC found that:

- all of the issues SRC identified had been noted by GMC’s Analysis Team and, consequently, featured in the GMC’s consultation report; and,
- with two exceptions (See Question 5, ‘No’ and ‘Not sure’ below) the prominence of each issue in GMC’s analysis was reflective of the number of citings above.

For the record, a summary of SRC’s analysis is shown below. Also, please note that the number of citings is typically greater than the number of qualitative responses overall because each qualitative comment typically cited more than one theme.

### Question 1: ‘Yes’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of citings</th>
<th>Ranking based on number of citings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Communication</td>
<td>37</td>
<td>1st</td>
</tr>
<tr>
<td>Equity</td>
<td>32</td>
<td>2nd</td>
</tr>
<tr>
<td>Appropriate / reasonable</td>
<td>28</td>
<td>3rd</td>
</tr>
<tr>
<td>Safety / Care</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>IMG</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Tests</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Europeans</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>IELTS</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Limit</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

---

20 Re Question 1, only the ‘Yes’ and ‘No’ responses were analysed. Too few ‘Not sure’ responses to merit detailed audit. Re Question 5, ‘Yes’, ‘No’ and ‘Not sure’ responses were analysed.

21 Note: All relevant working papers re SRC’s analysis have been passed on to GMC.
### Question 1: ‘No’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of citings</th>
<th>Ranking based on number of citings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test</td>
<td>10</td>
<td>1st</td>
</tr>
<tr>
<td>Equity</td>
<td>8</td>
<td>2nd</td>
</tr>
<tr>
<td>Europe / Europeans</td>
<td>8</td>
<td>2nd</td>
</tr>
<tr>
<td>IELTS</td>
<td>4</td>
<td>3rd</td>
</tr>
<tr>
<td>Employer responsible</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Role</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>IMG</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Limit</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Apt</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Effective Communication</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Safety / Care</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

### Question 5: ‘Yes’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of citings</th>
<th>Ranking based on number of citings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor should pay</td>
<td>17</td>
<td>1st</td>
</tr>
<tr>
<td>Outside scope</td>
<td>6</td>
<td>2nd</td>
</tr>
<tr>
<td>Refunds</td>
<td>5</td>
<td>3rd</td>
</tr>
<tr>
<td>Employer should pay</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Consistency</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Reasonable</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Concessions</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Appeals</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Tax deductable</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

### Question 5: ‘No’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of citings</th>
<th>Ranking based on number of citings</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMC should pay</td>
<td>18</td>
<td>1st</td>
</tr>
<tr>
<td>It depends</td>
<td>7</td>
<td>2nd</td>
</tr>
<tr>
<td>Refund if pass</td>
<td>5</td>
<td>3rd</td>
</tr>
<tr>
<td>Equity</td>
<td>5</td>
<td>3rd</td>
</tr>
<tr>
<td>Constency</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Complainant should pay</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Investigator should pay</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Reasonable</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Unwelcome</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>GMC to prove concern</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>UK state</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dr pay if fail</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>GMC pay if Dr fail</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>NHS should pay</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Provide free</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Outside scope</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Initially, SRC did not see the 1st issue above cited in GMC’s draft report of the ‘No’ responses. However, having fed this back to GMC, we are now satisfied that this has been addressed appropriately in the GMC’s final report.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of citings</th>
<th>Ranking based on number of citings (Top Three highlighted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistency</td>
<td>12</td>
<td>1st</td>
</tr>
<tr>
<td>It depends</td>
<td>9</td>
<td>2nd</td>
</tr>
<tr>
<td>Equity</td>
<td>7</td>
<td>3rd</td>
</tr>
<tr>
<td>Dr should pay</td>
<td>7</td>
<td>3rd</td>
</tr>
<tr>
<td>Refund if pass</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Reasonable</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Complainant should pay</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>GMC should pay</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Employer should pay</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>UK state should pay</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dr pay if test retaken</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Investigator should pay</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Outside scope</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Again, initially, SRC did not see the 1st issue above cited in GMC’s draft report of the ‘Not Sure’ responses. And again, having fed this back to GMC, we are now satisfied that this has been addressed appropriately in the GMC’s final report.

4.4 FINDINGS FROM ANALYSIS OF DATA SET 3: FREE FORMAT WRITTEN RESPONSES

In the context of the audit, SRC sought to assess:

- Completeness – the extent to which all of the response considered;
- Accuracy of analysis – in terms of assignment of the various aspects of the submission to the most appropriate consultation question; and,
- Completeness and accuracy of the identification of any additional relevant themes / issues raised by the respondent.

To achieve this, we reviewed each of the submissions in turn and compared them with the analysis prepared by GMC.

The results were as follows:

Summary...

<table>
<thead>
<tr>
<th>Analysis of 6 submissions from major bodies representing doctors</th>
<th>Completeness</th>
<th>Accuracy</th>
<th>Additional Relevant Themes Identified</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✔ 100%</td>
<td>✔ 100%</td>
<td>✔ 100%</td>
<td>See themes listed in the detail table below.</td>
</tr>
<tr>
<td>Response from</td>
<td>Completeness</td>
<td>Accuracy</td>
<td>Additional Relevant Themes Identified</td>
<td>Themes</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------</td>
<td>----------</td>
<td>----------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Royal College of Radiologists</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>Concerns re telemedicine including those operators outside EU.</td>
</tr>
<tr>
<td>Faculty of Forensic and Legal Medicine</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>Effective communication in 'legal fora'.</td>
</tr>
<tr>
<td>Scottish Government</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>Patient safety Skills to communicate effectively respective of country of origin. Support for amendment to Medical Act 1983</td>
</tr>
<tr>
<td>Royal College of Physicians</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>Support for amendment to Medical Act 1983</td>
</tr>
<tr>
<td>Welsh Language Medical Society</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>‘Fluency in English is all important in attaining accurate diagnosis’ ‘Linguistic fluency improves patient care… clinical, not abstract point’ Similar considerations should apply to Welsh language in Wales.</td>
</tr>
<tr>
<td>Medical Defence Union</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>✓ 100%</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
4.5 FINDINGS FROM ANALYSIS OF DATA SET 4: MEETINGS

In the context of the audit, SRC sought to assess:

- Completeness – the extent to which all of the notes from the meeting had been considered;
- Accuracy of analysis – in terms of assignment of the various points raised in the notes had been assigned to the most appropriate consultation question; and,
- Completeness and accuracy of the identification of any additional relevant themes / issues raised at the meeting.

To achieve this, we reviewed each of the submissions in turn and compared them with the analysis prepared by GMC. The results were as follows:

<table>
<thead>
<tr>
<th>Analysis of meeting notes from 2 out of the 6 meetings with key stakeholder groups</th>
<th>Completeness</th>
<th>Accuracy</th>
<th>Additional Relevant Themes Identified</th>
<th>Summary of Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✅ 100%</td>
<td>✅ 100%</td>
<td>✅ 100%</td>
<td>Proportionality</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multi-faceted cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Appraisal and revalidation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patients not speaking English</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Disability – Sign Language</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IELTS Test</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Same system for IMGs and European Doctors</td>
</tr>
</tbody>
</table>
### 4.6 FINDINGS FROM ANALYSIS OF DATA SET 5: GMC NEWS LINK

**SRC selected 20 (circa 5%) of these at random.**

In the context of the audit, SRC identified the key themes/ issues raised by this sample of respondents. We then assessed the extent to which these were reflected in GMC’s analysis of this data set overall (Annex C of GMC’s Consultation Report).

### Data Set 5: GMC News Link Comments

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of citings</th>
<th>Ranking based on number of citings (Top Three highlighted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Communication</td>
<td>8</td>
<td>1st</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
<td>2nd</td>
</tr>
<tr>
<td>Equity</td>
<td>3</td>
<td>2nd</td>
</tr>
<tr>
<td>Europe / Europeans</td>
<td>2</td>
<td>3rd</td>
</tr>
<tr>
<td>IELTS</td>
<td>2</td>
<td>3rd</td>
</tr>
<tr>
<td>PLAB</td>
<td>2</td>
<td>3rd</td>
</tr>
<tr>
<td>Should have been done before</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Patient care</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Revalidation</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

SRC was satisfied that the top three issues identified in the sample were prominent in Annex C of GMC’s consultation report. We also confirmed that the remaining issues are cited in other sections of GMC’s consultation report and were not necessarily repeated specifically in Annex C and this point is made clear to the reader on page 40 of GMC’s report.
4.7 GENERAL COMMENTS ON THE AUDIT OF QUALITATIVE DATA

The tables show the results of SRC’s analysis of a sample of qualitative data.

☑️ In brief, the points identified by the GMC Analysis Team were substantively the same points as those identified independently by SRC.

We would stress that there are at least three possible explanations for the specific themes that SRC has identified in its audit not appearing exactly like GMC’s Analysis:

- The classification of qualitative information is inherently subjective. Consequently, it is conceivable that GMC has classified or ‘contained within’ the same issues under different headings / descriptions which is not evident to SRC because we, understandably, do not and could not, have the same intimate level of knowledge of and familiarity with the overall consultation data set; we are merely auditing specific section. Consequently, it is wholly reasonable that a level of apparent difference would arise as a direct consequence of this.

- The issues are reflected in other parts of GMC’s analysis overall (i.e. beyond the specific sections of the Summary Analysis Papers analysed by SRC for the purposes of this Audit); or,

- The issues were considered by GMC to be outside the scope of this consultation.
The General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations Order of Council 2014

1 Final drafting points are still to be agreed with Department of Health.
2014 No. ****

HEALTH CARE AND ASSOCIATED PROFESSIONS

DOCTORS

The General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations Order of Council 2014

Made *** 2014
Laid before Parliament *** 2014
Coming into force *** 2014

At the Council Chamber, Whitehall the *** day of *** 2014

By the Lords of Her Majesty’s Most Honourable Privy Council

The General Medical Council has made the General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations 2014 which are set out in the Schedule to this Order, in exercise of the powers conferred by sections 29A(2) to (4), 29B(1)(1A), (1B), (2D) and (3), 29E(1) to (2A), and 29J(2E) and (3) of the Medical Act 1983(a).

In accordance with section 29J(5) of that Act, the General Medical Council has consulted with such bodies of persons representing medical practitioners, and such medical practitioners, as appeared to the General Medical Council requisite to be consulted.

By virtue of section 29J(4) of that Act such Regulations shall not have effect until approved by order of the Privy Council.

Citation and commencement

1. This Order may be cited as the General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations Order of Council 2014 and comes into force on *** 2014.

Privy Council approval

2. Their Lordships, having taken these Regulations into consideration, are pleased to and do approve them.

---

SCHEDULE

The General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations 2014

These Regulations are made by the General Medical Council in exercise of the powers conferred by sections 29A(2) to (4), 29B(1)(1A), (1B), (2D) and (3), 29E(1) to (2A), and 29J(2E) and (3) of the Medical Act 1983.

In accordance with section 29J(5) of that Act, the General Medical Council has consulted with such bodies of persons representing medical practitioners, and medical practitioners of any such description, as appeared to the General Medical Council requisite to be consulted.

Citation, commencement and interpretation

1.—(1) These Regulations may be cited as the General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations 2014 and come into force on *** 2014.

(2) In these Regulations “the Licence to Practise and Revalidation Regulations” means the General Medical Council (Licence to Practise and Revalidation) Regulations 2012.

Amendments to the Licence to Practise and Revalidation Regulations

2.—(1) The Licence to Practise and Revalidation Regulations are amended as follows.

(2) In Regulation 3 (grant or refusal of a licence)—

(a) at the beginning of paragraph (1) insert “Subject to paragraph (1A),”;

(b) after paragraph (1), insert—

“(1A) The Registrar may refuse to grant a licence to practise—

(a) under paragraph (1)(a), (c) or (d); or

(b) upon restoration of the practitioner’s name to the register where the practitioner’s name had been erased from the register under the provisions set out in subparagraphs (i) or (ii) of paragraph (1)(b) before the coming into force of the General Medical Council (Licence to Practise) Regulations 2009,


to a person in any case where the person has not demonstrated the necessary knowledge of English.

(2A) In determining whether a person has demonstrated the necessary knowledge of English under paragraph (1A) the Registrar must take account of the guidance published by the General Council under section 29G(2A) of the Act and such evidence as a person provides of his knowledge of English in accordance with that guidance.”;

(c) for paragraph (5) substitute—

“(5) Where in the Registrar’s opinion it is reasonable to do so for the purpose of determining whether to grant a licence to practise, including a determination as to whether a practitioner has the necessary knowledge of English, the Registrar may—

(a) by notice to the practitioner, request that the practitioner—

(a) Scheduled to S.I. 2012/2685.

(b) Scheduled to S.I. 2009/2739 which came into force on 16th November 2009 and were repealed S.I. 2012/2685.
(i) provide further evidence or information,
(ii) undertake, at the practitioner's own cost, an assessment designed to evaluate the practitioner's knowledge of English;
(b) carry out other investigations.”
(d) for paragraph (8), substitute—
“(8) The Registrar may refuse to grant a licence to practise if the Registrar considers that—
(a) without reasonable excuse, the practitioner has—
   (i) failed to satisfy the requirements of paragraph (3),
   (ii) failed to provide any evidence or information requested by the Registrar under paragraph (5)(a)(i),
   (iii) failed to undertake an assessment requested by the Registrar under paragraph (5)(a)(ii), or
(b) in respect of a practitioner applying for a licence under paragraph (2) or falling within paragraph (1), having taken account of any evidence as to the practitioner's knowledge of English, that the practitioner has failed to demonstrate the necessary knowledge of English.”.
(3) In Regulation 6 (revalidation), after paragraph (8), insert—
“(8A) For the avoidance of doubt, an assessment under paragraph (8) may include an assessment of the practitioner's knowledge of English.”.

Given under the official seal of the General Medical Council this xx day of xx 2014.

[Name]
Chair

[Name]
Chief Executive and Registrar

EXPLANATORY NOTE
(This note is not part of the Order)

The Regulations amended by this Order amend the General Medical Council (Licence to Practise and Revalidation Regulations 2012 (scheduled to SI 2012/2685) (“the Regulations”).
8 - Making sure all licensed doctors have the necessary knowledge of English to practise safely in the UK

Annex E

The General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2014

1 Final drafting points are still to be agreed with Department of Health.
The General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2014

Made - - - *** 2014
Laid before Parliament *** 2014
Coming into force - - *** 2014

At the Council Chamber, Whitehall the *** day of *** 2014

By the Lords of Her Majesty’s Most Honourable Privy Council

The General Medical Council has made the General Medical Council (Fitness to Practise) (Amendment) Rules 2014 which are set out in the Schedule to this Order, in exercise of the powers conferred by section 35CC(1) and paragraphs 1(1), (2) and (2A), 5A(1), (2), (3) and (3A), and 5C(1) of Schedule 4 to the Medical Act 1983(a).

In accordance with paragraph 1(6), 5A(9) and 5C(9) of Schedule 4 to that Act, the General Medical Council has consulted with such bodies of persons representing medical practitioners, and medical practitioners of any description, as appeared to the General Medical Council requisite to be consulted.

By virtue of paragraph 1(7), 5A(9) and 5C(9) of Schedule 4 to that Act such Rules shall not come into force until approved by order of the Privy Council.

Citation and commencement

1. This Order may be cited as the General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2014 and comes into force on *** 2014.

Privy Council approval

2. Their Lordships, having taken these Rules into consideration, are pleased to and do approve them.

[Name]

(a) 1983 c.54. Section 35CC was inserted, and paragraph 1 and 5A of Schedule 4 was substituted, by S.I. 2002/3135. Paragraph 5C of Schedule 4 was inserted by SI 2014/xxx.
SCHEDULE

The General Medical Council (Fitness to Practise) (Amendment) Rules 2014

These Rules are made by the General Medical Council in exercise of the powers conferred by section 35CC(1) and paragraphs 1(1), (2) and (2A), 5A(1), (2), (3) and (3A), and 5C(1) of Schedule 4 to the Medical Act 1983.

In accordance with paragraph 1(6), 5A(9) and 5C(9) of Schedule 4 to that Act, the General Medical Council has consulted with such bodies of persons representing medical practitioners, and medical practitioners of any description, as appeared to the General Medical Council requisite to be consulted.

Citation, commencement and interpretation

1.—(1) These Rules may be cited as the General Medical Council (Fitness to Practise) (Amendment) Rules 2014 and come into force on *** 2014.

(2) In these Rules, “the Fitness to Practise Rules” means the General Medical Council (Fitness to Practise) Rules 2004(a).

Amendments to the Fitness to Practise Rules

2.—(1) The Fitness to Practise Rules are amended as follows.

(2) In Rule 2 (interpretation), after the definition of “application”, insert—

““assessment of knowledge of English” means an assessment which is designed to evaluate whether the practitioner has the necessary knowledge of English.”.

(3) In Rule 7 (investigation of allegations)—

(a) at the end of paragraph (3), insert—

“(3A) The Registrar may direct that the practitioner undertake an assessment of knowledge of English in accordance with Schedule 3.

(b) for paragraph (6), substitute—

“(6) Where the Registrar receives information that—

(a) the practitioner has failed to submit to, or comply with, an assessment under Schedule 1 or 2;

(b) having submitted to an assessment under Schedule 1, the practitioner has failed to comply with reasonable requirements imposed by the Assessment Team; or

(c) the practitioner has failed to undertake an assessment of knowledge of English in accordance with Schedule 3 or (as the case may be) provide the information requested in accordance with that Schedule,

the Registrar may—

(i) refer the allegation for determination by a FTP Panel,

(ii) in a case falling within sub-paragraph (b), refer the practitioner to a FTP Panel for the purposes of making a direction under paragraph 5A(3) of Schedule 4 to the Act, or

(iii) in a case falling within sub-paragraph (c), refer the practitioner to a FTP Panel for the purposes of making a direction under paragraph 5C(4) of Schedule 4 to the Act.”.

(4) In Rule 10 (undertakings), in paragraph (6) after “Schedule 1 or 2” insert “or directing that the practitioner undertake an assessment of knowledge of English in accordance with Schedule 3”.

(5) In Rule 11 (warnings), in paragraph (7), in sub-paragraph (d), after “Schedule 1 or 2” insert “or an assessment of knowledge of English in accordance with Schedule 3”.

(6) In Rule 13A (investigation following referral), after “Schedule 1 or 2” insert “or directing that the practitioner undertake an assessment of knowledge of English in accordance with Schedule 3”.

(7) In Rule 17 (procedure before a FTP Panel)—

(a) in paragraph (4)—
   (a) in sub-paragraph (a), omit “or”,
   (b) in sub-paragraph (b), at the end, insert “or”, and
   (c) after sub-paragraph (b) insert—
      “(c) that the practitioner undertakes an assessment of knowledge of English in accordance with Schedule 3.”;

(b) in paragraph (5), after “paragraph 4(b)” insert “or (c)”; and

(c) after paragraph (7) insert—
      “(7A) Where a practitioner has been referred under rule 7(6)(iii) for failure to undertake an assessment of knowledge of English, or for failure to provide the information requested in respect of that assessment the FTP Panel may dispose of the case, where it considers it appropriate to do so, by suspending the practitioner’s name from the register or imposing conditions on his registration in accordance with paragraph 5C(4) of Schedule 4 to the Act.”; and

(d) for paragraph (8), substitute—
      “(8) Subject to paragraph (7) and (7A), where a practitioner has failed to submit to, or comply with, an assessment under Schedule 1 or 2, or has failed to undertake an assessment under Schedule 3 or has failed to provide the information requested in respect of that assessment, and—
      (a) there is credible evidence before the FTP Panel that the practitioner’s fitness to practise is impaired,
      (b) a reasonable request has been made by the Registrar to the practitioner that he undertake, submit to, or comply with the assessment, or provide information in accordance with Schedule 3 (as the case may be), and
      (c) no reasonable excuse for such failure has been provided by the practitioner,
      the FTP Panel may take such failure into account in determining the question of whether the practitioner’s fitness to practise is impaired.

(8) In Rule 19 (functions of registrar), in paragraph (1)—

(a) in sub-paragraph (a), omit “and”;

(b) in sub-paragraph (b), at the end, insert “or”;

(c) after sub-paragraph (b) insert—
      “(c) direct that the applicant undertake an assessment of knowledge of English in accordance with Schedule 3.”.

(9) In Rule 23 (action on receipt of a restoration application), in paragraph (1)—

(a) in sub-paragraph (a), omit “and”;

(b) in sub-paragraph (b), at the end, insert “or”; and
(c) after sub-paragraph (b) insert—

“(c) direct that the applicant undertake an assessment of knowledge of English in accordance with Schedule 3.”.

(10) In Rule 24 (procedure at a restoration hearing), in paragraph (2), in sub-paragraph (g) after “Schedule 1 or 2” insert “or undertake an assessment of knowledge of English in accordance with Schedule 3”.

(11) In Rule 37A (panel undertakings), in paragraph (1), after “Schedule 1 or 2” insert “or directing that the practitioner undertake an assessment of knowledge of English in accordance with Schedule 3”.

(12) In Schedule 1 (performance assessments)—

(a) After paragraph 1 insert—

“1A. In this Schedule a reference to the standard of the practitioner’s professional performance includes the standard of the practitioner’s knowledge of English, in particular, whether the practitioner has the necessary knowledge of English.

(b) In paragraph 3—

(i) After sub-paragraph (2) insert—

“(2A) For the purposes of assessing the standard of a practitioner’s professional performance, the Assessment Team may direct, in accordance with the provisions set out in Schedule 3, a practitioner to undertake an assessment of the practitioner’s knowledge of English.”

(c) After sub-paragraph (4) insert—

“(5) Where the practitioner has undertaken an assessment of knowledge of English following a direction under these Rules the results of the assessment must be included in the report referred to under sub-paragraph (4).”.

(13) After Schedule 2 (Health Assessments) insert—

“SCHEDULE 3

KNOWLEDGE OF ENGLISH ASSESSMENTS

1. In this Schedule “assessment of knowledge of English” means an assessment which is designed to evaluate whether a practitioner has the necessary knowledge of English.

2. The Registrar, Assessment Team or FTP Panel (as the case may be) may direct the practitioner to—

(a) undertake an assessment of knowledge of English and;

(b) to provide information in respect of that assessment as specified in the direction.

3. Where a direction is made under paragraph 2, The Registrar, Assessment Team or FTP Panel (as the case may be), must without delay serve a notice on the practitioner—

(a) requiring the practitioner to undertake an assessment of the practitioner’s knowledge of English within such period as shall be specified in the notice, which period shall be no shorter than 30 days, and no longer than 90 days, beginning with the date of the notice, and

(b) specifying any information which the practitioner is required to provide in respect of that assessment.

4. Where a practitioner has undertaken an assessment under this Schedule and informed the relevant person of the information requested under paragraph 3(b), the Registrar, Assessment Team or FTP Panel (as the case may be) may make a request to the relevant person for disclosure of that information.
5. Where a request is made under paragraph 4 the relevant person shall disclose the information requested to the person making the request.

6. In this Schedule “relevant person” means the Registrar, Assessment Team or FTP Panel (as the case may be)."

Given under the official seal of the General Medical Council this xx day of xx 2014

[Name]
Chair

[Name]
Chief Executive and Registrar

EXPLANATORY NOTE
(This note is not part of the Order)

The Rules amended by this Order amend the General Medical Council (Fitness to Practise) Rules 2004 (scheduled to SI 2004/2608) (“the Fitness to Practise Rules”).
The General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) (Amendment) Regulations Order of Council 2014

1 Final drafting points are still to be agreed with Department of Health.
The General Medical Council has made the General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) (Amendment) Regulations Order of Council 2014 which are set out in the Schedule to this Order, in exercise of the powers conferred by section 31A of the Medical Act 1983(a).

And whereas, by virtue of section 31A(2) of that Act, such Regulations shall not have effect until approved by order of the Privy Council.

Citation and commencement

1. This Order may be cited as the General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) (Amendment) Regulations Order of Council 2014 and comes into force on *** 2014.

Privy Council approval

2. Their Lordships, having taken these Regulations into consideration, are pleased to, and do approve them.

[Name]
Clerk of the Privy Council

(a) 1983 c.54. Section 31A was added by the Medical (Professional Performance) Act 1995 c.51, and amended by S.I. 2002/3135 and S.I. 2010/234.
SCHEDULE

The General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) (Amendment) Regulations 2014

These Regulations are made by the General Medical Council in exercise of the powers conferred by section 31A of the Medical Act 1983.

Citation and commencement

1. These Regulations may be cited as the General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) (Amendment) Regulations 2014 and come into force on *** 2014.

Amendments to the General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations 2004

2.—(1) The General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations 2004(a) are amended as follows.

(a) after paragraph (2), insert—

“(2A) The Registrar may apply rule 23(1)(b) and (c) of Part 6 of the Fitness to Practise Rules as is in the Registrar’s opinion appropriate to the consideration of the restoration application under paragraph (3) as if the application for restoration we made under that rule.

(b) in paragraph (3)—

(i) in sub-paragraph (a)(i), omit “and”,
(ii) in sub-paragraph (a)(ii), at the end, insert—

“(iii) any information, documents or evidence obtained by virtue of paragraph (2A); and”.

Given under the official seal of the General Medical Council this xx day of xx 2014.

[Name]
Chair

[Name]
Chief Executive and Registrar

(a) Scheduled to S.I. 2004/2609 which has been amended by S.I. 2009/2763.
EXPLANATORY NOTE
(This note is not part of the Order)

This Order amends the General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations 2004 (scheduled to SI 2004/2609).
Making sure all licensed doctors have the necessary knowledge of English to practise safely in the UK

The General Medical Council (Restoration following Administrative Erasure) (Amendment) Regulations Order of Council 2014

1 Final drafting points are still to be agreed with Department of Health.
The General Medical Council (Restoration following Administrative Erasure) (Amendment) Regulations Order of Council 2014

Made - - - - *** 2014
Laid before Parliament *** 2014
Coming into force - - *** 2014

At the Council Chamber, Whitehall the *** day of *** 2014

By the Lords of Her Majesty's Most Honourable Privy Council

The General Medical Council has made the General Medical Council (Restoration following Administrative Erasure) (Amendment) Regulations 2014 which are set out in the Schedule to this Order, in exercise of the powers conferred by section 31 of the Medical Act 1983 (a).

And whereas, by virtue of section 31(10) of that Act, such Regulations shall not have effect until approved by order of the Privy Council.

Citation and commencement

1. This Order may be cited as the General Medical Council (Restoration following Administrative Erasure) (Amendment) Regulations Order of Council 2014 and comes into force on *** 2014.

Privy Council approval

2. Their Lordships, having taken these Regulations into consideration, are pleased to, and do approve them.

/Name/
Clerk of the Privy Council

(a) 1983 c.54. Relevant amendments have been made to section 31 by S.I. 2002/3135, S.I. 2006/1914 and S.I. 2010/234.
SCHEDULE

The General Medical Council (Restoration following Administrative Erasure) (Amendment) Regulations 2014

These Regulations are made by the General Medical Council in exercise of the powers conferred by section 31 of the Medical Act 1983.

Citation and commencement

1. These Regulations may be cited as the General Medical Council (Restoration following Administrative Erasure) (Amendment) Regulations 2014 and come into force on *** 2014.

Amendments to the General Medical Council (Restoration following Administrative Erasure) Regulations 2004

2.—(1) The General Medical Council (Restoration following Administrative Erasure) Regulations 2004(a) are amended as follows.

(2) In Regulation 4 (restoration procedure where fitness to practise issues arise) —

(a) after paragraph (2), insert—

“(2A) The Registrar may apply rule 23(1)(b) and (c) of Part 6 of the Fitness to Practise Rules as is in the Registrar’s opinion appropriate to the consideration of the restoration application under paragraph (3) as if the application for restoration were made under that rule.”.

(b) in paragraph (3)—

(i) in sub-paragraph (a)(i), omit “and”,

(ii) in sub-paragraph (a)(ii), at the end, insert—

“(iii) any information, documents or evidence obtained by virtue of paragraph (2A); and”.

Given under the official seal of the General Medical Council this xx day of xx 2014.

[Name]
Chair

[Name]
Chief Executive and Registrar

(a) Scheduled to S.I. 2004/2612 which has been amended by S.I. 2009/2764.
EXPLANATORY NOTE
(This note is not part of the Order)

This Order amends the General Medical Council (Restoration following Administrative Erasure) Regulations 2004 (scheduled to SI 2004/2612).