

The Recognition of Professional Qualifications and Regulation of Professions: Call for Evidence

Introduction

The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training. There are approximately 336,000 doctors on the UK medical register. Of these, approximately 299,000 have a licence to practise.*
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.
- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

Summary

In responding to this call for evidence, we seek to support the UK Government's aim in making sure that we have a regulatory environment that supports jobs, gives fair access to global professionals and maintains high standards. The broad themes of our evidence seek to:

- Secure a separate system of recognition of professional qualifications for the healthcare sector. We emphasise that the healthcare sector is not the same as the wider business and professional services sector due to the uniqueness of the patient safety aspect.
- Reiterate the need for legislative reform of the Medical Act, especially the recognition of international doctors, in order to create a fair system for doctors to access the medical register, regardless of where in the world they qualified.

* Figure correct as of 29/09/2020

- Inform future decisions on how the UK regulates professionals more generally in order to reflect our values around openness and transparency, the proportionality of regulation, and the key importance of equality, diversity and inclusion.

Key points

The healthcare sector is unique in that its principal objective is to support the health and well-being of the entire UK population. The COVID-19 pandemic has shown how crucial a well-supported and effective NHS and healthcare system in all four countries of the UK is, both in dealing with the direct effects of the pandemic and also with the ensuing backlog of healthcare. A vital part of the healthcare system are the doctors, nurses and other healthcare professionals who need to be supported in carrying out their roles. But it's equally important that the healthcare workforce is regulated both proportionately and effectively so that patient safety is always protected.

Unlike some other regulated professions, the risk of harm is greater for the healthcare professions due to the nature of the work that they do. Patient safety is, and must remain, the principal consideration when assessing the proportionality of regulation in the healthcare sector.

The UK's exit from the European Union provides an opportunity to review the regulation of the UK medical profession as well as the recognition and regulation of professions more widely. However, during these discussions it is vital that the UK healthcare system continues to be protected, supported and enhanced. We recognise that the Department for Business, Energy & Industrial Strategy (BEIS) has an entirely legitimate focus on the interests of consumers and in promoting competition. However, this may also involve the weighing of legitimate trade-offs between the economic objectives of the four UK governments and their other objectives in supporting the NHS and healthcare systems. These trade-offs, and the potential to focus on the requirements of some sectors at the expense of others, may provide sub-optimal outcomes for the UK healthcare system overall.

This risk is compounded because, as the consultation paper notes, there are a very substantial number of professions in the UK, regulated often in very different ways, with different economic and regulatory objectives between sectors and with professionals working across the private, public and not-for-profit sectors. It thus seems clear that a 'one size fits all' regulatory approach may not well serve such a mixed economy of professions and professionals and risks giving rise to a complex and brokered approach that in fact results in serving no sector effectively.

The UK's withdrawal from the European Union allows a more tailored sector by sector approach that could support some regulated sectors in enabling the economy to recover and thrive and allowing others, such as the healthcare professions, to continue to build a first class healthcare system. That's why, for many years, the GMC has worked closely

with Government to promote a more bespoke and flexible system for the recognition of medical professional qualifications than has been possible within the EU framework.

This review provides a timely opportunity to put patient safety at the forefront of public policy and to apply consistent standards through a fair and transparent system for all overseas trained doctors to join the medical register, regardless of where in the world they qualified. It can also assist the UK Government's desire to build and grow the UK healthcare workforce, most especially now in the circumstances of the global pandemic. The UK Government has established Healthcare UK to leverage the UK's capabilities in healthcare. Through our own advisory service GMCSI* we too are seeking opportunities to share our expertise in medical regulation with countries whose systems are less well-developed.

As such, our response to the consultation reflects our regulatory role in protecting patients – but it is important to also see these issues in the wider context of the UK's international reputation and influence, and their value to the UK economy. Medicine is now a global profession. Along with Ireland the UK is more dependent on international doctors than many other OECD countries[†], hence we need registration processes that balance speed and patient protection, which will be best served by the tailored approach to healthcare regulation that we promote.

Revising the current model of recognition also provides an opportunity to modernise the UK medical education and training system. This will ensure that it is more flexible and responsive to meeting the needs of UK patients, 21st century healthcare provision and medical trainees.

In conclusion, the UK's exit from the European Union provides us with a valuable opportunity to create a new bespoke framework that respects the particularity of the healthcare sector and its focus on patient safety, and allows it to diverge, if necessary from the frameworks for other, non-health and safety critical professions.

Current regulation of professions

Please tell us in which nation(s) you are a regulator of a profession

The GMC is the regulator for the medical profession in the four countries of the UK. We have a strong and effective presence through our offices in England, Northern Ireland, Scotland and Wales and our regional teams across England. Through them we build and maintain relationships with patients, relevant organisations and politicians. This helps us target our services and interventions to the different UK healthcare systems. It also means

* <https://www.gmc-uk.org/about/what-we-do-and-why/consultancy-and-advisory-services>

† https://www.oecd-ilibrary.org/social-issues-migration-health/recent-trends-in-international-migration-of-doctors-nurses-and-medical-students_5ee49d97-en

we hear the views of key interest groups and regulatory and improvement bodies across the UK. Together, this helps us develop relevant policy and guidance.

Please state the profession(s) you regulate

All doctors who wish to work in the UK must register with the GMC. We also have responsibility for regulating all stages of medical education and training. We do this by setting the standards and requirements that must be met; and checking that they are met, through our quality assurance activity. Our statutory remit also covers taking action when we believe a doctor may be putting the safety of patients at risk.

In July 2019, the Department of Health and Social Care (DHSC), with the support of the four UK governments, asked us to regulate physician associates (PAs) and anaesthesia associates (AAs). We're pleased to support the development of these valuable professions, working alongside doctors as part of the multi-professional team. Regulation will help to increase the contribution PAs and AAs can make to the UK healthcare system, while keeping patients safe. New legislation is needed before regulation can start and is planned to be introduced in the second half of 2021. PAs and AAs work in a minority of countries overseas, and are especially well-established in the USA, Canada, Australia and New Zealand. To date there has been relatively little international movement of these professionals compared to doctors.

Please outline the rationale for regulation within your sector

Healthcare is a unique sector. Unlike some other regulated professions, the risk of harm is greater for the healthcare professions. Patient safety is, and must remain, the principal consideration when assessing the proportionality of regulation in the healthcare sector.

Patients across the UK must have confidence in their health professionals. The preservation of that trust and of patient safety is paramount. Professional regulation must create a framework that maintains safe and effective clinical practice, sets appropriate standards of conduct, and provides the foundation for effective relationships between patients and health professionals.

In considering the role of regulation for healthcare professionals, decision makers must remain vigilant about the purpose of the regulatory measures imposed. When asking questions about whether regulation impacts access to a profession or whether it facilitates overseas mobility, these considerations must be balanced against the principles of protecting the public in a proportionate way.

Please outline any evidence you have on the consumer protection impacts provided by your regulations

We have left this answer intentionally blank as our regulation is about the protection of patients and the public rather than the public acting as consumers.

International recognition

Please outline your process(es) of recognising someone with an international qualification. In your answer, please include details of how this differs from the process of recognising a domestic applicant, the rationale for this/ the reasons why this is the case, and the costs of administering this route.

If you have different processes for different international routes (e.g. for candidates from the EU, USA, Australia, or due to any Mutual Recognition Agreements you hold), please include details on the differences between them.

Every doctor who applies for registration will have an appropriate route which is defined in the Medical Act 1983. These routes are largely defined by the applicant's nationality, level of experience and country of qualification.

There are currently three broad categories of registration which are set out below. Within each category there will be several individual routes relating to that category:

- a** UK – for graduates of UK medical schools regardless of their nationality.
- b** EEA – for all nationals of European Economic Area (EEA) countries except the UK, and for UK nationals with a European primary qualification. This route is currently governed by the mutual recognition of professional qualifications directive.
- c** International medical graduate – for all nationals of countries outside the EEA and for UK nationals with a primary medical qualification (PMQ) awarded in a country outside the EEA.

Doctors who have qualified outside the UK and the EEA are known as international medical graduates (IMGs). Following the end of the transition period on 31 December 2020, all non-UK doctors including EEA doctors will be classed as IMGs. Before they are granted registration with a licence to practise, they must satisfy us that they:

- Hold an acceptable PMQ that meets our criteria
- Possess the knowledge, skills and experience for practice in the UK
- Have no outstanding fitness to practise concerns
- Have the necessary knowledge of English to practise safely in the UK

For a full overview of the current international registration process, please see Annex A.

From 2024 we will introduce the Medical Licensing Assessment (MLA), an assessment that aims to create consistency and commonality in entry to the UK medical register for both UK graduates and IMGs who would have sat our Professional and Linguistic Assessments Board (PLAB) test. The MLA will test the essential professional skills, knowledge and

behaviours needed for safe practice in the UK and focus on assessing readiness for practice, managing uncertainty and delivering patient-centred care.

Once statutory regulation is introduced for physician associates (PAs) and anaesthesia associates (AAs), we need to ensure we have a fair and robust process for recognising overseas qualifications. We are already aware of PA courses that are run in other countries such as the USA, Canada, Australia and New Zealand, and we are working closely with the Faculty of Physician Associates to understand the structure and content of PA courses globally.

It is likely that we will begin registering PAs and AAs with overseas qualifications towards the end of 2021. Our proposed approach is for there to be a single route for those with overseas qualifications, in which we will assess the acceptability of a qualification. Applicants will be expected to demonstrate their knowledge skills and experience through evidence of their qualification, a national pre-registration assessment, evidence of English language and a declaration as to their fitness to practise. These are the same requirements which will be expected of UK qualified PAs and AAs.

[Please outline any additional steps and their resource implications that you face in processing applicants with international qualifications?](#)

The fee for joining the medical register is currently £406 for all doctors irrespective of nationality or PMQ unless they qualify for a discount.

There may be additional fees payable by doctors from outside the UK in specific circumstances, the most common being either those who sit our Professional and Linguistics Assessment Board (PLAB) test or those who apply to join our Specialist or GP registers. The PLAB fees total £1,114 and cover our costs. IMGs who will take the MLA when it replaces the PLAB test will also need to pay the relevant fees that will apply.

For applications to the Specialist register and GP register, there is a fee of £1,668 for each application made via the Certificate of Eligibility for Specialist Registration or Certificate of Eligibility for GP Registration routes known as CESR and CEGPR. This is paid by the applicant. Previous activity-based costing on the CESR and CEGPR routes has shown that applications actually cost around £1,800 to process – the majority of the current £1,668 fee (£1,099) goes to the royal colleges/faculties. The GMC incurs a 'loss' of around £300 per application. However, this can vary hugely depending on the specialty of application, the amount of evidence provided, where the referees are based, and other factors.

[With reference to any of the additional steps outlined above, what would you suggest are the priorities for the UK Government in considering future ways to recognise international qualifications? Please include any details on what an ideal system could look like, as well as how it could operate. Please consider what the priorities would be for the profession you regulate.](#)

The UK has a very high international reputation in the healthcare sector and specifically in medical education and training. There has been particularly rapid growth in the numbers of IMGs joining the UK workforce in recent years, from just over 2,500 in 2015 to more than 10,000 in 2020. Our medical schools are highly attractive to international students. In the 2018/9 academic year, 16% of UK students taking up their first degree at medical school did not live in the UK prior to starting their course*.

International graduates joining our register for postgraduate training make a significant contribution to the NHS in the specialties in which they are training. Just under one in seven doctors in GP or specialty training were IMGs in 2020.

In February 2018, GMC Council adopted the following principles for regulation:

- Prioritise public protection over any other consideration. Although we have an interest in promoting workforce mobility and expansion, this cannot be to the detriment of patient safety
- Ensure that existing standards are maintained and seek to provide assurance that the registration framework is robust
- Be evidence based and developed in collaboration with internal and external stakeholders where appropriate
- Ensure equitable treatment between different cohorts of doctors where appropriate, in compliance with equality legislation and our statutory duties and obligations
- Seek to maximise efficiency. The outcomes of the programme must not result in undue burden being placed on applicants, stakeholder organisations or the GMC

Any new system must not undermine the important patient safety checks that we make on doctors wishing to practise medicine in the UK. It is essential that healthcare professional regulators have control over access to their registers and can determine the standards of entry, regardless of the country in which an applicant has qualified.

We have a well-established system in place for the general registration of IMG doctors that is underpinned by legislation that provides flexibility and discretion. However, this is currently not the case for all our international registration routes or types of registration. By contrast, our statutory processes for granting GP and specialist registration are particularly prescriptive and onerous. In practice it can be very challenging for an applicant to meet those requirements, especially if they have not practised in the UK previously.

* HESA Student Record 2002/2003 to 2018/2019

We would prefer a more flexible legislative framework based not on demonstrating individual equivalence, but on demonstrating capability to practise as a GP or consultant in the UK. For several years, we have been seeking updated legislation that reflects the standard set out for general registration across all our pathways and types of registration. Our preference is to develop a simplified registration framework with a consistent standard that equally applies to all doctors, wherever they qualify.

We recognise that there is a balance between proportionate regulation that meets the needs for patient safety and the urgent matter of workforce supply which we are committed to supporting the UK Government in achieving. However, it is essential that any changes to the registration process provide continued assurance for patients. To do this, we must have a deep understanding of how medical education and training operates in any potential partner country and assurance that the standards of education and training are comparable to those in the UK.

Any future system for the recognition of international professional qualifications also needs to align with the new immigration rules that are due to come into force at the end of the EU exit transition period. A streamlined system to recognise professional qualifications will not be sufficient if the UK immigration rules prevent qualified doctors from living and working in the UK.

[Do you require legislation to give you powers to make changes to your international recognition routes?](#)

Without legislative reform, we cannot make changes to our international recognition routes for specialist or GP registration for doctors coming to work as consultants or GPs in the UK. We do not require legislation to make changes to our international recognition routes for general registration as flexibility is already embedded in these routes.

We need legislative reform if we are to streamline our processes to deliver a model of regulation that is as flexible and adaptable to the needs of the modern medical workforce as it should be. We are currently forced to work under an historic patchwork of highly prescriptive legislation which results in systems that are slow, bureaucratic and burdensome. That is bad for patients as well as for doctors.

Introducing statutory regulation for physician associates and anaesthesia associates will also require necessary changes to the Medical Act 1983, as well as amendments to or the creation of rules and regulations to help us fulfil our statutory functions. We have been working closely with the DHSC to identify the legislative change required.

[What level of dialogue do you maintain with your international counterparts? Please outline the benefits and challenges to cooperation. Please also outline if you are a member of any international networks of regulators, what they are and your experience with them.](#)

We have long established and extensive contacts with our European and international counterparts. We work closely with regulators from around the world and have benefited

greatly from sharing experiences and learning from best practice in other jurisdictions. Models of regulation differ greatly around the world but the sharing of best practice and the intelligence that we have gathered from our European and international networks has greatly enhanced the development of our regulatory model and operational efficiency.

The GMC is a founding member of the International Association of Medical Regulatory Authorities* (IAMRA) which was created in 1994. The purpose of IAMRA is to promote effective medical regulation worldwide by supporting best practice, innovation, collaboration, and knowledge sharing in the interest of public safety and in support of the medical profession. We have hosted international IAMRA conferences in the UK and have shared the UK model of revalidation widely, helping to raise patient safety standards around the world.

Along with the French and German medical regulators, the GMC coordinates a network of medical regulators from across Europe which we established in 2010 at the request of the European Commission. The European Network of Medical Competent Authorities† (ENMCA) brings together over 25 European regulators and has successfully influenced MEPs and the European Commission to make important amendments to the mutual recognition of professional qualifications directive, including clarifications on the language requirements for health professions, the introduction of a legal duty to share fitness to practise information across Europe, and the exclusion of doctors from the first phase of the European professional card.

We are also the coordinator of the Healthcare Professionals Crossing Borders‡ (HPCB) initiative. HPCB started as a voluntary partnership of European professional healthcare regulators in 2005 during the UK Presidency of the EU. The seeds for a legal duty to share fitness to practise information were sown through several voluntary information sharing agreements the HPCB network brokered and which regulators across Europe adopted. These eventually formed the basis of the legal duty in the revised mutual recognition of professional qualifications directive. The influence of the HPCB agreements on European Commission thinking has been recognised and quoted in various Commission publications.

What are your priorities for supporting UK professionals on your register to have access to their profession in other countries? Please outline any Government support that would help.

We issue Certificates of Good Standing (also known as Certificates of Current Professional Status) directly to medical regulatory authorities in other countries. These certificates show whether, at the time of issuing, the doctor is registered with us and if there are, or

* <https://www.iamra.com/>

† <http://www.enmca.eu/>

‡ <http://www.hpcb.eu/>

have been, any restrictions on their practice in the UK. This allows doctors who have held registration with us to make an application to practise medicine in other countries.

Do you have any provisions for the recognition of professional qualifications held by refugees residing in the UK? If yes, please detail what these are and why you have implemented these provisions. If no, please detail why not.

We have always worked closely with refugee doctors and their representative organisations to help them register with us so that they can practise here and care for patients in the UK. As of March 2020, there were 313 doctors with refugee status on our register with a licence to practise.

Refugee doctors are eligible for several discounts*. We cover the fees for the primary source verification[†] of their medical degree and offer two free attempts at PLAB 1, with PLAB 2 discounted to half price. The application fee can be paid in 10 instalments if requested. In terms of English language testing, refugee doctors can get access to the Occupational English Test (OET), at their preferred test venue, free of charge under the OET scholarship.

We also have a member of staff within the GMC with the specific role of liaising with refugee doctor representative bodies and providing support to refugee doctors applying for registration.

Developing professional standards and regulation

Please describe the process by which UK professionals gain qualifications to enter the profession, including detail on the types of education and training they must undergo and how long it takes to complete them.

Before becoming a UK doctor, students first must obtain a degree in medicine from a medical school whose medical degrees we accept as meeting the criteria we set and publish. Courses normally last five years, or four years for a graduate entry programme. They involve basic medical sciences as well as clinical experience in a variety of environments including hospitals, general practices and community medical services.

After graduation, students enter the two-year Foundation Programme run by the UK Foundation Programme Office. They are provisionally registered with a licence to practise from us while completing the first year. Full registration is awarded when they have successfully completed year one.

* <https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/fees-and-funding/help-for-refugees>

† <https://www.gmc-uk.org/registration-and-licensing/join-the-register/before-you-apply/primary-source-verification-for-international-medical-graduates/how-much-does-it-cost-to-verify-my-qualification>

Doctors are then eligible to enter specialty training. This ranges from three years (for a GP) to eight years (for many hospital-based specialties). Additional training after reaching GP or consultant status is optional.

Once a doctor satisfies all the requirements of a GMC-approved training programme they are awarded a Certificate of Completion of Training (CCT). The CCT is then used to join either the GP register to be recognised as a GP, or the Specialist register to be recognised as a consultant.

Physician associates undergo two years (full time) postgraduate training, which is currently based on the Competence and Curriculum Framework for physician associates (Department of Health 2012). Training consists of intensive theoretical learning in medical sciences, pharmacology and clinical reasoning as well as over 1,400 hours of clinical placement experience in community and acute care settings. PAs are also required to pass the PA National Assessment.

Anaesthesia associates complete a postgraduate diploma which is also studied over 24 months with an additional three months probationary period served in clinical practice to conclude training. The course comprises 12 modules which introduce trainee AAs to the clinical practice of anaesthesia, applied physics, the anaesthetic machine, and monitoring principles. The final assessments are based on the management of life-threatening emergencies and advanced practice. Successful graduation requires passing assessments at eight and 24 months.

We are in the process of gathering more information about both courses and assessments to prepare for quality assurance once regulation starts. We are currently working with the Faculty of Physician Associates, the Royal College of Physicians and the Royal College of Anaesthetists to develop a new curriculum for both PAs and AAs, in line with GMC standards outlined in *Excellence by Design*^{*}, as well as ensuring assessments meet these standards.

Please describe the process you offer for professionals who have gained the relevant UK qualifications to be brought onto your register.

Most graduates of UK medical schools will go on to complete the two-year UK Foundation Programme. They can make an online application for provisional registration as soon as they graduate which is valid for a maximum of three years and 30 days (1,125 days). After successfully completing their first year of the Foundation Programme (FY1) they will need to make a further online application for full registration to allow them to move on to their second year (FY2). Provided the applicant's fitness to practise is not impaired, they

* <https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/excellence-by-design>

are entitled to registration. They can only be refused registration on fitness to practise grounds.

How often do you review your processes and standards? In your answer, please describe both formal and informal ways this is carried out (e.g. via consultancy, membership surveys) and include detail of any changes you have recently made based to this process.

Our operational processes are routinely audited and reviewed through a programme of continuous improvement and internal audit overseen by a committee made up of GMC Council members and senior GMC staff. Additionally, we review incoming complaints and correspondence to identify and address themes and make improvements.

We are also reviewed on an annual basis by the Professional Standards Authority (PSA) who gather evidence for each healthcare professional regulator to see if we have met their *Standards of Good Regulation**. The Standards describe the outcomes the PSA expects regulators to achieve for their four regulatory functions: guidance and standards, education and training, registration, and fitness to practise, as well as a set of general standards.

Our policies and guidance are periodically reviewed by internal working groups to ensure they remain up to date. Ad hoc reviews will take place if issues are highlighted via operational teams, appeals outcomes, complaints, updated research, stakeholders, interdependent policy/process changes or amendments to relevant legislation. Depending on the nature, scale and impact of the policy changes we will engage with relevant stakeholders through scheduled meetings, bespoke workshops, reference communities, and both targeted or full public consultations. Policy changes are communicated to stakeholders via emails, letters, e-bulletins, scheduled meetings and updated webpages.

Recent changes made as a result of a review of our processes and standards include the introduction of primary source verification of qualifications, clarifying our position on English language evidence, updating our guidance on insurance and indemnity, reviewing our approach to sharing historical fitness to practise sanctions with overseas regulators and updating health declarations at the point of registration. We have also introduced new standards for postgraduate medical curricula, outcomes for graduates and delivery of medical education and training. Future changes include a review of our publication *Good medical practice*† which will commence next year.

Thinking about key changes that have been made to your qualification processes, what has been the cause for this change?

* https://www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-of-good-regulation-2018-revised.pdf?sfvrsn=ce597520_11

† <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice>

The most substantial change to our qualifications process in recent years has been the introduction of a requirement on international doctors to primary source verify their qualifications in advance of applying for registration. Verification is carried out by the Educational Commission for Foreign Medical Graduates (ECFMG) through an online system where they verify the qualification is genuine by checking directly with the awarding institution. This change was introduced to provide an additional level of assurance in our processes that qualifications were legitimate. This level of assurance is becoming increasingly important as doctors increasingly cross borders to practise medicine.

A further change was the granting of powers to all regulators to check registrants had adequate and appropriate indemnity and insurance. The cause for this change was the decision by government to give all regulators these powers following a series of legal cases.

In 2018 we made changes, following a public consultation, to *Outcomes for graduates** and the practical procedure list. This is because we wanted to ensure that what we expect new doctors from UK medical schools to know and be able to do is kept current and relevant.

Do you feel that the current standards you set, against which applicants are assessed to enter onto the register, are a fair reflection of the level of skill, training, education, and experience required to practise their profession? Please explain your answer.

Outcomes for graduates sets out what newly qualified doctors, from all medical schools who award UK primary medical qualifications, must know and be able to do. The outcomes were revised in 2019 following extensive consultation and we believe are a fair reflection of the skill, training, education and experience required for UK graduates to practise as a newly qualified doctor.

In terms of the standards for doctors who qualified elsewhere in the world, we have a well-established system in place for the general registration of IMG doctors that is underpinned by legislation that provides flexibility and discretion. However, this is currently not the case for all our international registration routes or types of registration. By contrast, our statutory processes for granting GP and specialist registration are particularly prescriptive and onerous. In practice it can be very challenging for an applicant to meet those requirements, especially if they have not practised in the UK previously.

We would prefer a more flexible legislative framework based not on demonstrating individual equivalence, but on demonstrating capability to practise as a GP or consultant in

* <https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/outcomes-for-graduates>

the UK. For several years, we have been seeking updated legislation that reflects the standard set out for general registration across all of our pathways and types of registration. Our preference is to develop a simplified registration framework with a consistent standard that equally applies to all doctors, wherever they qualify.

From 2024 we will introduce the Medical Licensing Assessment (MLA), an assessment that aims to create consistency and commonality in entry to the UK medical register for both UK graduates and IMGs who would have sat our Professional and Linguistic Assessments Board (PLAB) test. The MLA will test the essential professional skills, knowledge and behaviours needed for safe practice in the UK and focus on assessing readiness for practice, managing uncertainty and delivering patient-centred care.

Please detail any principles of regulation you follow (e.g. proportionality and transparency) and how you uphold them, and whether they support you in your duties as a regulator.

We have five core organisational values underpinning everything we do.

Integrity – We are honest and share what we see. We listen to our partners but remain independent.

Excellence – We are a learning organisation, committed to achieving high standards.

Collaboration – We work with others to support safe, high-quality care.

Fairness – We respect people and treat them without prejudice.

Transparency – We are open and account for our actions.

These values form the basis on which we operate. We want every decision we make, every interaction we have and every email we write to embody these values. We regularly evaluate how we think we are living up to these values and seek the views of others on how they think we are doing.

Please detail any requirements you may place on the professionals you regulate and why they are necessary. If you do not impose any requirements, please justify your reasons for not doing so.

The GMC has a statutory responsibility to provide guidance to doctors on standards of professional conduct, professional performance and medical ethics. Our guidance sets out the values and principles that underpin good medical practice and describes how the principles can be applied. This helps doctors to provide good care and to respond to the complex ethical problems they may face in their professional lives. Our guidance applies to all registered doctors, whether or not they hold a valid licence to practise or regularly see patients.

The core professional standards expected of all doctors are set out in *Good medical practice*, which covers fundamental aspects of a doctor's role, such as working in

partnership with patients and treating them with respect. We provide more detailed guidance on ethical principles that most doctors will use every day, such as consent and confidentiality, and specific guidance on a range of areas such as raising concerns about patient safety, child protection and caring for people who are dying. Doctors are expected to use professional judgement to apply the principles to specific situations and must be prepared to justify and explain their actions.

Our guidance has become a key reference point in the current structures and processes for wider healthcare regulation, service provision and inspection in the UK. It is also embedded within the GMC's other statutory functions. Notably, our guidance:

- Informs the medical undergraduate outcomes and postgraduate curricula
- Provides the basis of revalidation for all doctors
- Provides a benchmark for considering complaints about a doctor's fitness to practise. The guidance doesn't set the threshold at which a doctor is fit to practice, but serious or persistent failure to follow it may lead us to investigate or take action through fitness to practise proceedings
- Sets out, in a clear and accessible way, what patients and the public can expect from their doctors

We also publish *Achieving good medical practice** guidance which contains various standards for medical students ahead of becoming registered doctors.

Our guidance is written in the context of current UK legislation and takes into consideration variations in England, Scotland, Wales and Northern Ireland. In developing the guidance, the GMC has a statutory duty to take into account the views of our key interest groups. This includes patients and the public, the medical profession, the NHS and other healthcare providers, medical schools and medical royal colleges. As a result, the guidance provides an agreed and independent benchmark by which to evaluate a doctor's performance. Although the guidance is addressed to doctors, it also demonstrates to patients what they should expect from their doctor.

The GMC has powers to check any doctor practising in the UK has adequate and appropriate insurance or indemnity in place and to remove the doctor's licence or refuse to grant a licence if they don't. Parliament passed healthcare legislation in 2013 allowing us to:

- Check that any doctor practising in the UK has the appropriate insurance or indemnity in place, when we have concerns that this might not be the case

* https://www.gmc-uk.org/-/media/documents/achieving-good-medical-practice-20200729_pdf-66086678.pdf

- Remove a doctor's licence to stop them from practising altogether, if we learn that they don't have appropriate insurance or indemnity in place or if they fail to give us the information we ask for
- Refuse to grant a licence to a doctor if they can't assure us that they'll have the appropriate insurance or indemnity in place by the time they start practising in the UK.

The type and level of insurance or indemnity required depends on where a doctor works, whether they are employed or self-employed and the type of work they do.

In addition, every licensed doctor who practises medicine must revalidate. Revalidation supports doctors to develop their practice, drives improvements in clinical governance and gives patients confidence that their doctor is up to date. Details of the revalidation process can be found in our response to question 23 on continuing professional development.

[Please describe the process by which you determine your application fees. Please set out any principles or guidelines you adhere to when determining fee amounts.](#)

Our fees are set at a level that covers the cost of regulation and incorporate no element of profit or subsidy over the medium term. We currently constrain annual fee increases in line with the Consumer Price Index (CPI).

[Please detail any changes that you are considering for your sector to ensure the profession you regulate stays relevant to current challenges. Does current regulation allow for you to make these changes?](#)

Our statutory focus is centred on the vital issue of patient safety, but we also want to play our part in the delivery of wider system reform. Making sure we have sufficient medical professionals with the right talents, expertise and experience is crucial to this endeavour.

Attracting more senior doctors to the UK

The UK remains an attractive destination for overseas doctors. This year, around 10,000 international medical graduates will join the register, along with 7,500 graduates of UK medical schools and 2,000 graduates from EEA countries.

While we're seeing the number of international graduates grow, we struggle to attract consultant-level doctors or GPs from overseas into the UK. A significant factor causing this is the legislative framework, and there is a big opportunity if the Government is prepared to make changes to that legislation.

Current regulation is prescriptive, bureaucratic and burdensome. It requires international doctors and senior associate specialists who wish to practise as consultants and GPs in the UK to provide around 1,000 pages of information and spend around nine months gathering evidence to support their application. Even then only half are approved.

More autonomy over the specialist and GP registration process would allow us to assess doctors' capabilities in a more flexible, less onerous, manner.

This would dramatically reduce the bureaucratic burden on senior IMGs looking to practise in the UK and could increase the speed at which they join the NHS workforce. It could also benefit existing senior staff and associate doctors already in the UK looking to progress their careers, further increasing the supply of consultants and GPs.

Unleashing the potential of medical education and licensing post-EU exit

Medical education is an area ripe for reform and we believe that EU exit may provide an opportunity for positive change.

UK undergraduate and postgraduate training is currently informed by the mutual recognition of professional qualifications directive, which stipulates 5,500 training hours and a minimum of five years to become a doctor.

The UK's exit from the EU presents the opportunity to introduce more flexibility, focusing on outcomes rather than inputs. The legislative changes required to replace the directive could create greater flexibility, which could in turn promote social mobility by widening routes into medicine and help address doctor shortages in some of our towns and regions. For example, by creating more tailored content for graduate entry programmes or for people to become doctors having first qualified in a different profession.

Any changes would, of course, be dependent on ensuring that the high standards expected of medical graduates are maintained, and we would need support from the Government to ensure that this could be assured. We are committed to working with government on how to take advantage of the opportunities of more flexible education and training without reducing the attractiveness of a UK medical education to EEA nationals who may wish to have a portable qualification (EEA nationals constituted around 7% of all UK medical students in the 2018 to 2019 academic year). This may require a hybrid model of some primary and specialist medical qualifications continuing to abide by the directive's minimum training times with other education and training courses allowing for fast-tracked qualifications.

To that end we believe that from 2024, by providing a common and consistent approach to ensuring that doctors have the knowledge, skills and behaviours to practise safely, the medical licensing assessment can act as an important enabler of such innovation and change. Future developments to the MLA, supported by legislative change, would also be a relevant consideration in any thinking about potential changes to the point of full registration which, if agreed, would enable new graduates to obtain full registration on completion of their medical school degree rather than, as now, after additionally completing the first year of the Foundation Programme.

Ensuring fitness to practise cases are fast, few and fair

Fitness to practise is a vital part of our work to protect public safety and confidence in doctors. Nevertheless, prescriptive legislation makes this slower and more cumbersome than it needs to be. We are grateful to the Government for its commitment to give us and other regulators more autonomy over this process.

We have already made changes, such as introducing provisional enquiries, which take less time to conclude than full investigations. Legislative reform would allow us to do much more, reducing the number of unnecessary investigations, reducing the stress on doctors and reducing the cost of the process to us and the profession.

By giving regulators a discretion to investigate rather than a duty, we could focus resource on the areas of highest risk and of greatest concern. It would also allow alternative approaches, like local resolution (where appropriate), and would improve the potential for doctors to learn from their mistakes.

Enabling medical associate professionals (MAPs) to fully support doctors

We are delighted to have been asked to take on the role of regulating physician associates and anaesthesia associates. Our regulation of this vital group will help maximise their contribution to the workforce. There are approximately 2,000 PAs and 200 AAs currently. Once regulation is introduced, we expect the numbers to rise to around 5,000 in total by 2023.

We are mindful that the Government's current stated intention is to introduce statutory regulation for PAs and AAs only. However, there is an opportunity at this early stage to future-proof the legislation to allow other medical associate professional roles – such as surgical care practitioners and advanced critical care practitioners – to be brought into regulation if the Government saw fit to do so in future.

Legislation framed in this broad way will help facilitate the future development of these and other MAPs roles so regulation can better respond to the changing needs of the healthcare workforce and the public it serves.

Better governance and information sharing

The safety of patients and doctors alike continues to be undermined by weak clinical governance such as that concerning Responsible Officers (ROs).

By strengthening existing regulation, ROs would be better equipped to monitor the fitness to practise of all doctors within their designated body, and to identify and prevent rogue clinical practice. ROs should be the first line of patient defence in monitoring the fitness to practise of their doctors across the UK, not just England as is now the case.

Whether a doctor is trust-grade, consultant or locum, better sharing of information where there are concerns and better understanding of doctors' scope of practice is fundamental to protecting patients.

Supporting a profession under pressure

In 2019 we published three independent reports which add to the collective understanding of the pressures faced by doctors and the healthcare system and some of the solutions:

- *Independent review of gross negligence manslaughter and culpable homicide** – a review of how the law on gross negligence manslaughter and culpable homicide is applied to medical practice
- *Fair to refer?*[†] – research to understand why some groups of doctors are referred for fitness to practise concerns, more or less than others
- *Caring for doctors, Caring for patients*[‡] – a report looking at the main factors impacting doctors' and medical students' wellbeing and the action needed to create more compassionate working environments.

The reports evidenced the impact of these pressures on patient care. This reflects our wider regulatory role to protect, promote and maintain the health, safety and wellbeing of the public.

Prior to the pandemic, we were making progress to deliver the recommendations for us and in February 2020, we held roundtables in each of the four countries of the UK to bring together leaders from across the UK's health systems to discuss the recommendations, and to identify areas for action. While discussions and priorities varied in each country, reflecting local issues and environments, participants across all the events agreed to support a collective, system wide response to deliver change.

The majority of our partnership working has been paused due to the pandemic; however, we have been able to continue some of our work to address recommendations to improve equality and diversity, investigation and educational processes and procedures. One example of this is providing data to feed into the MWRES (Medical Workforce Race Equality Standard) and looking at ways we can change our processes to try to reduce the disproportionate number of BME doctors referred into our fitness to practise procedures.

Please detail any steps you take to help make sure that your standards and processes are adaptive, support innovation and promote social mobility.

* https://www.gmc-uk.org/-/media/documents/independent-review-of-gross-negligence-manslaughter-and-culpable-homicide--final-report_pdf-78716610.pdf

† https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf

‡ https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

Our operational processes are routinely audited and reviewed through a programme of continuous improvement and internal audit overseen by a committee made up of GMC Council members and senior GMC staff. Additionally, we review incoming complaints and correspondence to identify and address themes and make improvements. This ensures that our standards and processes are adaptive to the changing needs of the healthcare sector, of professionals and of patients.

We are also reviewed on an annual basis by the Professional Standards Authority (PSA) who gather evidence for each healthcare professional regulator to see if we have met their *Standards of Good Regulation**. The Standards describe the outcomes the PSA expects regulators to achieve for their four regulatory functions: guidance and standards, education and training, registration, and fitness to practise, as well as a set of general standards.

We carry out equality analysis when we begin work to develop our professional standards. We review the equality analysis at key stages in the process (for example before and after a public consultation) to make sure we've implemented what we've learnt about the potential impact on those who share protected characteristics and mitigated any such impact, where possible. We also use the equality analysis to help us to develop our plans for engaging and consulting on new professional standards in ways that positively promote equal opportunities, improve access, participation in public life and good relations.

A diverse medical profession that reflects the population is linked to better patient outcomes. Doctors from diverse backgrounds should be encouraged and supported to become leaders within and outside the health service. We have equality, diversity & inclusion (ED&I) requirements of medical schools where we outline what we expect of them in terms of attracting a diverse range of the population into the profession. This is reinforced by the quality assurance measures we have in place and the evidence we ask schools to provide to demonstrate their compliance with this.

The Medical School's Council Selection Alliance leads on selection work which includes widening participation, and the GMC are members of the oversight group which meets once or twice a year. We are supportive of the Selection Alliance's work in this area[†]. Our involvement has helped to ensure that widening participation models are not net contributors to the causes of differential attainment. We have shared our understanding, driven by data such as our National Training Survey, of the importance of supportive, responsive learning environments, to make sure that once widening participation students are selected, they are not then left to their own, unsupported, devices.

* https://www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-of-good-regulation-2018-revised.pdf?sfvrsn=ce597520_11

[†] <https://www.medschools.ac.uk/our-work/selection/msc-selection-alliance>.

Continuous Professional Development

Please detail any continuous professional development that is required for professionals to remain on your register. Please include detail on how often this should take place, in what form, as well as the benefits of adhering and consequences of not adhering to these requirements.

Every licensed doctor who practises medicine must revalidate. Revalidation supports doctors to develop their practice, drives improvements in clinical governance and gives patients confidence that their doctor is up to date.

All doctors with a licence collect examples of their work and participate in an annual appraisal where they review what they're doing well and how they can improve. An important part of this is checking what their patients think about the care they give. For appraisal and revalidation, doctors collect and reflect on:

- Feedback from their patients
- Feedback from people they work with
- Any incidents or significant events they have been involved in
- Any continuous professional development they have completed and what they've learnt
- Quality improvement measures they have taken to improve their practice
- Any complaints or compliments about them.

Every year, doctors review and discuss their work with a trained appraiser. Together, they agree a plan for how the doctor can build on what they do well and any further development for the next year.

Experienced senior doctors (called Responsible Officers) are statutorily required to have appraisal and other local clinical governance systems in place to support doctors to practise safely and routinely review their work. If the doctor needs extra support, or if there are any serious problems, the Responsible Officer takes action to address this straight away. Responsible Officers periodically confirm to the GMC that doctors remain up to date and are fit to practise. Based on this, we decide if the doctor can keep their licence.

To support doctors in the current COVID-19 pandemic, local providers paused appraisals and we made the decision to move revalidation recommendations back by one year, allowing doctors to focus on clinical care. As we restart these processes, we want to embed our learning from the pandemic, and we've identified several ways to enhance revalidation, and make local clinical governance, including appraisal, stronger whilst reducing bureaucracy.

We're doing this by encouraging the rebalancing of appraisal to include a wellbeing and developmental focus for doctors, allowing them to reflect on the experience of the pandemic and identify where they can develop to provide better patient care. We're also challenging partners and employers to strip away unnecessary bureaucracy within appraisals and we're doing the same internally with revalidation.

Local governance can also be strengthened further by improving the Responsible Officer Regulations, to remove ambiguity and standardise them, which will reduce bureaucracy and improve patient safety.

Diversity and inclusion

Do you collect data on the diversity of both your UK and international applications? For example, on gender or ethnic background.

We collect diversity data for all registrants, although giving us this information is optional as applicants may choose to not answer the question. The data collection for gender, ethnicity and age (via proxy of date of birth) has been in place for some time now and we have strong data quality. The recording of data for disability, sexual orientation and religion or belief was implemented in 2016 and therefore the data we hold on registrants is not complete but is improving.

Please outline any steps you take to eliminate unconscious bias from your recognition process.

All staff within the organisation complete mandatory equality, diversity and inclusion (ED&I) eLearning that includes some content around bias. We have also delivered unconscious bias training to registration and revalidation colleagues over the years, most recently in 2019 to our Assistant Registrars (our key decision makers). Towards the end of 2020 we will begin a training needs review, which will look at what specific training on ED&I different cohorts of staff across the GMC will need to ensure understanding of ED&I and fair decision making. Unconscious bias training will be a key part of this review.

We complete an equality impact assessment as part of all policy development and will be undertaking an external fairness audit of registration and revalidation processes in 2021.

Please outline any steps you take to support job creation in the profession you regulate.

We don't control the numbers of UK graduates entering medical school and as such job creation is not within our remit. However, our international registration processes are an important gateway for entry to practise which helps to boost the NHS workforce. The introduction of GMC-regulated credentials will also support the expansion of the workforce in particular areas and allow doctors to change roles more easily. Medicine is rapidly evolving with new technologies and treatments. Credentialing will help the profession to adapt to the future needs of patients and maintain consistent standards across the UK, as well as building on existing skills, experiences and qualifications. It offers an opportunity

for doctors to continue to develop new skills and will complement postgraduate training programmes.

Please outline any steps you take to attract a diverse workforce to the profession you regulate.

Our ED&I priorities for the coming year are to:

- Establish and publish targets and measures for ED&I in regulation
- Work with our stakeholders to exert our influence over the system to tackle long standing racial inequalities
- Strengthen our regulatory requirements of those responsible for the design and delivery of medical education
- Establish and publish targets and measures for diversity in employment.

A diverse medical profession that reflects the population is linked to better patient outcomes. Doctors from diverse backgrounds should be encouraged and supported to become leaders within and outside the health service. We have ED&I requirements of medical schools where we outline what we expect of them in terms of attracting a diverse range of the population into the profession. This is reinforced by the quality assurance measures we have in place and the evidence we ask them to provide to demonstrate their compliance with this. The Medical School's Council Selection Alliance leads on selection work which includes widening participation, and the GMC are members of the oversight group which meets once or twice a year. We are supportive of the Selection Alliance's work in this area*.

We firmly believe disabled people should be welcomed to the profession and valued for their contribution to patient care. Our guidance *Welcomed and valued*[†] provides advice to help education providers on how best to support disabled medical students and doctors in training. This work has supported others, for example the Academy of Medical Royal Colleges has developed a process for all royal colleges on reasonable adjustment requests from neurodiverse candidates sitting postgraduate exams.

We know that differential attainment is an issue that affects many BME and IMG doctors, and this was also highlighted in our research *Caring for doctors, Caring for patients*. We have an established, ongoing programme of work looking at different ways that the GMC and others can introduce interventions to address the ethnic attainment gap with a focus on evaluating the impact of interventions and sharing the outcomes with others to build

* <https://www.medschools.ac.uk/our-work/selection/msc-selection-alliance>.

† <https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/welcomed-and-valued>

system-wide understanding of how to most effectively apply resources. We also monitor data on differential outcomes and share this with key stakeholders.

The information and insight we publish is also part of demonstrating how attractive the medical profession is to a diverse population. Our research *Fair to refer?* that we commissioned from Roger Kline and Dr Doyin Atewologun found that some groups of doctors face significant additional pressures relating to the environments and cultures in which doctors work. The report identified a number of factors underpinning the reasons that more BME doctors are referred into our fitness to practise processes. The research also found elements of differential treatment in working environments.

Fair to refer? also highlighted issues around the impact that ethnic difference can have when giving and receiving feedback and how the lack of timely, direct and honest feedback, that is sensitive to difference, can have a huge impact on a doctor's opportunity to demonstrate learning from mistakes and improvements to their practice. We are currently looking at ways we can improve access, fairness and timeliness to feedback for all doctors to enable their continuous learning and development and the early rectification of issues to mitigate a potential disproportionate fitness to practise referral.

Both *Fair to refer?* and our other independent research *The review into gross negligence manslaughter and culpable homicide* recommended that doctors who are new to the UK and doctors who work in more isolated roles, such as specialty and associate specialist (SAS) or locum doctors, need more support. The research highlights the need to include information about cultural and social issues, the structures of the NHS, contracts and organisation of training, induction, appraisal and revalidation, professional development plans and mentoring as part of a doctor's induction.

We have continued to expand our successful Welcome to UK practice programme for doctors from abroad and offer workshops and support to SAS and locum doctors through our field teams. This programme is promoted early in the journey of our contact with a potential registrant and may be a factor in attracting diversity.

We also use the data that we hold on registrants to publish an annual report on the makeup of the medical register. Our 2019 *'State of medical education and practice in the UK'* report highlighted that encouraging an inclusive, supportive culture in all work settings is critical. As part of this annual report, we report details of the diversity of doctors referred into our fitness to practise processes and what the outcome was of those referrals.

* <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk>

Additional information

Please detail any other information or evidence that you think we should take into consideration during this Call for Evidence.

Annex A

Registration process for International Medical Graduates

Background

- 1** Registration with a licence to practise is the legal status that allows doctors to exercise the rights and privileges associated with practising as a doctor in the UK. Doctors who have qualified outside the UK and the European Economic Area (EEA) are known as international medical graduates (IMGs). Before they are granted registration with a licence to practise, they must satisfy the GMC that they:
 - a** Hold an acceptable primary medical qualification (PMQ) that meets our criteria
 - b** Possess the knowledge, skills and experience for practice in the UK
 - c** Have no outstanding fitness to practise concerns
 - d** Have the necessary knowledge of English to practise safely in the UK

Primary medical qualification

- 2** All IMGs must have an acceptable primary medical qualification (PMQ) that meets all our criteria:
 - a** It must have been awarded after a programme of study, comprising at least 5,500 hours over a minimum period of years, depending on circumstances
 - b** The qualification must be awarded by an institution listed in the World Directory of Medical Schools*.
 - c** The institution listed in the directory must have sufficient contact details (address or email address, fax or telephone number) to allow verification of the qualifications it has issued
 - d** The doctor must have done clinical rotations as part of their primary medical qualification, which has given them appropriate clinical experience. This means the clinical rotations:
 - must have been of an acceptable duration

* <https://www.wdoms.org/>

- included exposure to medicine and surgery
 - were overseen or approved by the institution the doctor attended
 - formed part of the overall programme of study.
- 3** Having an acceptable PMQ is only the beginning of the process. The applicant must then go on to provide evidence of their knowledge skills and experience, their knowledge of English and their fitness to practise in the UK as set out below.

Evidence of knowledge and skills

- 4** There are four main ways of demonstrating evidence of knowledge and skills:
- 4.1** PLAB test
 - 4.2** Acceptable postgraduate qualification
 - 4.3** Sponsorship
 - 4.4** Eligibility for entry to the Specialist or GP register
- 5** The majority of IMGs demonstrate that they have the necessary knowledge and skills by sitting and passing a two-part exam set by the GMC. This exam is known as the Professional and Linguistic Assessments Board (PLAB). This is in addition to their demonstrating that they have an acceptable PMQ.
- 6** The PLAB test is designed to assess whether IMGs have the knowledge and skills equivalent to those of a doctor at the start of Foundation Year 2 in the UK Foundation Programme. This is the point at which UK medical graduates gain full registration.
- 7** The PLAB test comprises two parts:
- i** Part 1 is a written paper of 200 single best answer multiple choice questions delivered at British Council venues around the world and at two sites in the UK. Candidates have a limit of four attempts; and must pass Part 1 before taking Part 2.
 - ii** Part 2 is an objective structured clinical examination delivered in the GMC's Clinical Assessment Centre in Manchester. Candidates must pass Part 2 within four attempts. This part of the exam comprises 18 ten-minute stations and two rest stations. Each station is designed to reflect a realistic activity or interaction with a patient in Foundation Year 2 and includes ethical as well as clinical challenges.
- 8** Candidates must pass Part 2 within two years of passing Part 1; and must register with the GMC within two years of passing Part 2.

- 9** Each part of the assessment is overseen by a panel of senior clinicians and medical educators who are GMC associates.
- 10** Alternatively, an IMG doctor may have an acceptable postgraduate qualification (PGQ) – a postgraduate qualification awarded in the UK or elsewhere that has been recommended to the GMC by one of the medical royal colleges as demonstrating that the holder must have obtained a level of knowledge and skill at least equivalent to an F2 doctor. Awarded within the past three years. A list of these is on our [website](#).
- 11** Sponsorship – a certificate of sponsorship from a GMC approved sponsor indicating that the applicant has been assessed by the sponsor against the framework submitted to and approved by the GMC as having the knowledge and skill necessary for practice under full registration.
- 12** Eligibility for entry to the Specialist or GP Register – by submitting a combined application for full registration and a [CESR or CEGPR](#).

Evidence of experience

- 13** Applicants must demonstrate evidence of successful completion of an internship (or a period of suitable postgraduate employment). This means they must have done at least 12 months' continuous medical practice in an approved training post in a public hospital. They must have done this either immediately before or after they graduated. The internship must have included:
 - at least three months in medicine and three months in surgery, which lasted between 12 and 18 months,or
 - at least six months in medicine and six months in surgery, which lasted for 18 months or longer.
- 14** The applicant will need to send the GMC a certificate or letter of completion from the relevant institution, which gives details of the dates and specialties covered during rotations.

Evidence of English language skills

- 15** All applicants must provide evidence that they have the necessary knowledge of English to practise safely in the UK. The vast majority do this by sitting and reaching the required standard in one of two tests recognised by the GMC – the International English Language Test (IELTS) or the Occupational English Test (OET).
- 16** Alternatively if their primary medical qualification was taught in English and is not one listed on our [website](#), they will not need to sit a test.

Fitness to practise in the UK

17 All applicants must demonstrate that there are no outstanding concerns about their practice in other jurisdictions. To do this they must:

- Provide their most recent five years' employment history
- Provide an employer's reference from their most recent employer
- Provide evidence of good standing from any jurisdiction where they currently hold registration or have done so within the most recent five years. This certificate must be provided by the GMC equivalent regulator in their home countries
- Complete a 13-question fitness to practise declaration and sign a declaration giving the GMC wide ranging powers to conduct further investigations and enquiries as we deem appropriate during the application

Primary source verification

18 From June 2018, all IMG applicants must also have their primary medical qualification independently verified before we grant their registration. Verification is carried out by an external organisation called the Educational Commission for Foreign Medical Graduates (ECFMG) through their online system – known as the Electronic Portfolio of International Credentials (EPIC) service. ECFMG will verify the qualification is genuine by checking this directly with the doctor's awarding institution.

19 IMGs have no entitlement to registration. The onus is on the applicant to satisfy us that they should be registered and that their fitness to practise is not impaired.

Final check

20 Once we are satisfied that the applicant has met all our requirements we invite them for a face to face meeting with specially trained staff at our London or Manchester offices to do an ID check and to review and check the originals of documents that were provided as part of their application. The ID check interview includes an assessment of identity document(s) and all other credentials. We take a photograph during this interview and this is added to the doctor's record.

21 The assessment of documents includes:

- Physical and light machine examination - each document is examined for signs of amendment, tampering or falsification focusing on names, identifying information, signatures, stamps, seals, dates, reference numbers and the general quality of the document.

- Matching the original to the scan received with the application for registration; with particular focus on names, identifying information, signatures, stamps, seals, dates and reference numbers.
- Making copies of original document(s).
- Matching identity document to samples which can be accessed in at least one of the following systems:
 - Keesing document checker – Keesing Technologies is a specialist provider of digital anti-counterfeiting and authentication solutions
 - PRADO (the European Commission’s database) - PRADO is a multi-lingual site for disseminating information on security features of authentic identity and travel documents to the public
 - The Bulgarian ID database
 - GMC approved folders
- Checking the MRZ (machine readable code) number on the ID using the facility in Keesing as needed.
- Checking the doctor is able to reproduce (within reason) and in our presence the signature on the identity document.
- Checking that any photographs of the doctor on their identity document and credentials are actually the person attending the ID check using the UK Border Agency standard 5-point check criteria.

22 Any document that does not pass all of these tests will be referred for further investigation or primary source verification and registration will not be granted, nor will the identity of the doctor be verified until a positive result is acquired.