Written evidence submitted by the General Medical Council (MRS0393)

Our role

The GMC’s role is to protect patients and improve medical education and practice across the UK. As part of this, we decide which doctors are qualified to work in the UK, we oversee UK medical education and training, and we set the standards that doctors need to follow throughout their careers. We also take action where necessary to prevent a doctor from putting the safety of patients – or the public’s confidence in the profession – at risk.

Written Evidence

Joint statement on regulating during the pandemic

Together with the other professional regulators across the UK, we prepared a joint statement on how we will carry out our roles during this time. In releasing this statement, we recognised the pressure that the pandemic will generate for the system will inevitably be exacerbated by staff shortages due to sickness or caring responsibilities. We were clear in our expectations of employers to ensure that all clinicians working in their organisations are supported.

We also advised doctors that “We want doctors, in partnership with patients, always to use their professional judgement to assess risk and to make sure people receive safe care, informed by the values and principles set out in their professional standards.”

Our guidance for doctors – information and advice for doctors in response to the pandemic

We understand that doctors are working under immense pressure as they respond to the coronavirus (Covid-19) pandemic. Our guidance provides a framework for ethical decision making and we have advised doctors to continue to follow it as far as they can.

We have developed resources to help guide and assist the profession at this time which can be found on the Covid-19 FAQ section of our ethical hub. They pull together and draw on the principles in existing guidance, demonstrating how they apply in the current circumstances, as well as signposting to other useful sources of information. They cover areas such as how doctors can look after their own health and wellbeing, how to conduct remote consultations effectively, and principles for doctors around decision making and consent.

Our core guidance, ‘Good medical practice’, also sets out what it means to be a good doctor and what patients can expect from their doctor. It makes it clear that doctors must treat patients fairly and with respect and never discriminate unfairly against them. Doctors should work in partnership with patients and give patients the information they want or need in a way they can understand, so they can make decisions about their care. They should treat patients as individuals and respect their views about their health, as well as their privacy and dignity.
In each review of our guidance we conduct rigorous equality impact assessments to ensure that their implementation will not adversely affect those who share protected characteristics and we consult and engage with diverse groups to inform the guidance as it develops.

**Ethical enquiries we’ve received about Covid-19**

We have received a significant number of enquiries into our ethical inquiry service since the start of the pandemic. In a preliminary analysis of 111 enquiries received in relation to Covid-19 received between 3rd March – 7th April, 11 enquiries discussed the impact of the virus and adapted approaches to delivering healthcare on both doctors and patients with protected characteristics. These included:

- A lack of access to emergency care for patients for whom English is not their first language (race),
- Elderly patients and those with disabilities in care homes being unable to receive access to routine care (age and disability),
- A lack of access to controlled medications via remote prescribing options for those with long-term health conditions and those requiring end of life care (disability),
- The lack of access to healthcare for patients with issues pertaining to mental capacity because of the limitations of telephone consultations (disability),
- Incompatibility between doctors’ religious beliefs in relation to facial hair and requirements for appropriately fitted PPE (religion)

**Health inequalities**

We recognise there has been consideration widely by stakeholders across the system of the impact of Covid-19 on health inequalities.

We released a [joint statement](#) with the NMC about advance care planning, which focusses on recent concerns about potentially unfair or discriminatory treatment of certain groups. This followed media reports that some GPs had sent inappropriate DNACPR letters to patients; and a public statement by Age UK and others raising concerns about the possible use of blanket DNACPR policies.

The Care Quality Commission (CQC) wrote to adult social care providers and GP practices with a statement prepared jointly with the British Medical Association, Care Provider Alliance and Royal College of General Practitioners. The statement sets out a shared position on the importance of advance care planning being based on the needs of the individual. We decided with the NMC that there would be merit in publishing a joint statement on the same issue, to reinforce our expectations of registrants.

We are considering equalities issues as part of the ongoing work to update and add to the Covid-19 related Q&As in our Ethical Hub.

**Covid-19 mortality rates in BME health professionals**
We welcome the announcement by the government that there will be an official inquiry into why BME people appear to be disproportionately affected by Covid-19. We hope that this inquiry will provide critical insight and learning on the seriousness of health inequalities for the health sector and specifically the medical profession to inform responses now and in the future.

We have been contacted by members of the BME Doctors Forum, an independent forum that we host and engage with chaired by Professor Iqbal Singh, about the emerging evidence that Covid-19 is having a disproportionate effect on people from BME backgrounds. We are also aware that early analysis indicates a possible overrepresentation of BME health and care professionals among coronavirus fatalities.

We have heard from our engagement with the profession that this understandably is causing a significant amount of anxiety and concern for BME doctors. We acknowledge that some employers are responding to both the level of concern and the potential risks. We welcome the letter from Sir Simon Stevens and Amanda Pritchard on 29 April, which recommended that, on a precautionary basis, employers should risk-assess staff at potentially greater risk and make appropriate arrangements accordingly.

The announcement of urgent research on the impact of Covid-19 specifically on people working in health and social care from BME backgrounds is welcomed. We have recently published a number of reports that have relevance to the National Institute for Health Research (NIHR) research priorities, particularly in relation to this aspect of the research topics that are being supported:-

“Work related challenges to wellbeing, physical and mental health as a result of the Covid-19 environment, including coping mechanisms (positive and negative), and support and interventions that are sensitive to religious and cultural needs, as appropriate”.

There is a great deal of speculation about the factors that could be contributing to the disproportionate impact of the virus on BME doctors, and the inquiry will hopefully provide valuable understanding. We would draw the attention of the inquiry to the three reports we published in 2019, following independent research we commissioned:

- **Caring for doctors, caring for patients:** How to transform UK healthcare environments to support doctors and medical students to care for patients, by Dame Denise Coia and Professor Michael West

- **Fair to refer?** Reducing disproportionality in fitness to practise concerns reported to the GMC, Dr Doyin Atewologun and Roger Kline

- Gross negligence manslaughter and culpable homicide in medical practice, chaired by Leslie Hamilton
The findings and recommendations from all three reports include common challenges relating to the environments and cultures in which doctors work, and the impact of systems pressures on medical practice. They all found that some groups of doctors face significant additional pressures. ‘Fair to Refer’ identified a number of factors underpinning the reasons that more BME doctors are referred into our fitness to practise processes. The research found elements of differential treatment in working environments that may also be relevant lessons to consider in the context of this inquiry.

All these reports contain detailed evidence and findings that are pertinent to the research topics, but to demonstrate a few the findings are included below:

- different groups of doctors have different experiences of working environments that have a negative impact on their wellbeing
- some groups of doctors are treated differently
- some doctors are not provided with the feedback or support they need
- doctors may be more likely to attend work while unwell than other healthcare workers
- large numbers report being unwell or burnt out, but this is not reflected in sickness absence rates
- younger and female doctors are more likely to access confidential services
- BME and IMG doctors may be less likely to raise concerns due to fear of repercussions
- socio-economic status may also dissuade doctors from speaking up

BME doctors are more likely to be SAS grade doctors and locums, the findings in Fair to Refer suggests that those in such roles are more likely to be isolated and less supported due to the nature of the posts. Additionally, GP posts occupied by BME doctors are more likely to be geographically isolated.

These factors combined with unconscious bias and a lack of strong support networks mean BME doctors are at increased risk of feeling isolated and being reported for performance concerns. Fair to Refer found that that, ‘in a culture where individuals are blamed for errors caused or contributed to by such factors, ‘outsiders’, who are perceived not to fit in or belong, are likely to be more at risk of ‘scapegoating’. It is therefore not surprising that such groups of doctors also reported they would not feel supported if they raised concerns and avoid challenge, even if role requirements are challenging. Such findings are undoubtedly applicable given the challenging circumstances doctors are facing during the pandemic. These concerning findings all suggest BME doctors are more likely to be isolated and unsupported and less likely to raise concerns than their white counterparts. These vulnerabilities, combined with the posts BME doctors are more likely to occupy, suggest that they may be at greater risk.
Following all three reviews, we accepted all recommendations that are for us to deliver and have already made progress on many of these. We recognised that more long term work is needed in partnership with others to address the more fundamental issues about healthcare environments and cultures identified in all three reports and, in February this year, we met with key system partners to identify priority areas for partnership working and action in each country of the UK to improve working environments for healthcare staff.

Following Covid-19, our key priorities now are to ensure we do not place pressure on partners during the crisis but respond where they request our help in relation to immediate staff needs and to provide online content for doctors. Our approach will have to be revisited after the crisis to reflect the changed landscape in which supportive work environments and cultures will be more important than ever.

We have also recently published the interim findings from our survey of specialty and associate specialist (SAS) and locally employed (LE) doctors. SAS and LEDs are a very diverse group of doctors that make up approximately a fifth of all licensed doctors in the UK. The SAS and LE doctor population are ethnically diverse, the majority gained their primary medical qualification (PMQ) outside of the UK and they have specific challenges and concerns. They are more likely to be older and undertaking patient facing roles. Therefore these doctors could potentially face greater risks during the pandemic given their relatively older age (with consequent greater likelihood of underlying health issues). Many SAS and LED doctors of told us their working environments are not as supportive as they should be. Almost a third of SAS and LE doctors don’t always feel they are treated fairly at work. One in four say they’ve been bullied, undermined or harassed in the last year. They also report being less able to raise concerns, as compared to trainees who responded to similar questions in the 2019 national training surveys. The results for burnout also indicate that this group of doctors are feeling the impact of system pressure. Just over a quarter of SAS doctors and nearly a third of LE doctors told us they feel burnt out because of their work.

Going forward we will consider how we can apply a Covid-19 lens across future research that is relevant to this context.

**Temporary and provisional registration**

Section 18A of the Medical Act (1983) enables the GMC to grant temporary registration to certain groups of individuals in order to potentially increase the capacity of the medical workforce during a UK wide emergency. Since 26 March 2020 we have granted temporary registration to 34,837 doctors. Four distinct cohorts of doctors have been granted temporary registration with a licence or had their licences returned for the duration of the emergency. Our equality analysis considered the impact on doctors who have been temporarily registered under Section 18A.

We have taken a careful and considered approach to the representation of the cohorts of doctors. We have developed a web hub of information to help doctors decide about being temporarily registered. That included information for doctors in at risk groups. We have
endeavoured to give temporary registration to as many doctors as possible in order to maximise the medical workforce in this emergency. However, we have also considered the potential risk to patients and taken this into account. We’ve also ensured that the process of temporary registration has been undertaken in an inclusive, fair and non-discriminatory way.

In terms of the demographic data we hold about the doctors who have recently been granted temporary registration under Section 18A of the Medical Act, we currently hold reliable data gathered over a number of years about their age, gender, nationality and where they obtained their Primary Medical Qualification.

Between 26 March 2020 and 2 April 2020, we granted temporary registration or a license to 34,837 doctors. Our data shows that:

- 60.7% are male and 39.3% are female. The average age of doctors in this category is 57. With over half falling into the ‘over 55’ age categories.
- 67.7% obtained their PMQ in the UK.
- 9% obtained their PMQ in an EEA country.
- 23.3% obtained their PMQ from a non-UK or EEA country.

Our data shows that doctors who have been granted temporary registration are more likely to be in the older age categories. There are many reasons why doctors in this cohort may have recently left the register or relinquished their licence to practise, although clearly some may have decided to retire from medical practise, having reached retirement age.

While it would not be appropriate to assume that doctors in the older age categories (and therefore more likely to share the protected characteristic of age) are unable or unwilling to return to the medical workforce, we’ve taken steps to ensure that they can opt out or have autonomy over the extent of their involvement. We’ve ensured that the process is as simple, straightforward and transparent as possible.

- All doctors have had the option to opt out of this arrangement.
- How to appropriately deploy doctors is considered between the relevant health department and individual doctors.
- Doctors still have autonomy over the amount and type of support they offer.
- The cohorts of doctors have been carefully chosen to assimilate quickly back into the healthcare environment.
- There will be no administrative or financial burden associated with temporary registration. They will not have to engage with the revalidation process. At the end of the emergency period their temporary registration will automatically be withdrawn.

We’ve also brought forward the provisional registration of final year medical students, so they can help with the emergency response if they choose to. There has been no change to the threshold to enter the register. Because we’ve implemented these measures as part of the response to the pandemic, we’ve waived the fees for those who have been given temporary registration, a temporary licence to practise, or early provisional registration.
We are also aware of the difficulties that some international doctors might be facing in obtaining a Certificate of Good Standing from the regulatory bodies of their home countries in light of Covid-19. We have encouraged any doctors who are struggling to obtain any of the standard evidence because of Covid-19, to seek our advice.

Registration of refugee doctors

Doctors (including refugees) who had not previously held registration with us have not been assessed before or provided evidence to meet our standards. Therefore, we have not included them in temporary registration. However, they are able to apply for standard registration in the usual way. We have reviewed applications and identified those who would be able to provide the required evidence quickly – these we have promoted up the applications queue so we can deal with them more quickly. Teams are also supporting doctors in a range of ways including extending timeframes for ID checks; gathering alternative evidence where we can accept it such as alternative English language evidence; and leaving applications open longer than our normal 90 days.

Due to the complexities of their situation and arrangements we have not automatically included refugee doctors in the cohorts granted temporary registration.

We know that RefuAid have been in touch with many MPs and ministers as part of their campaign for more refugee doctors to be added to the register. RefuAid have also been in touch with us with a list of 230 refugee doctors they think should be speedily registered. Many of these doctors were either waiting for a place on the English language course they run or are currently engaged in their language programme. 32 had taken the Occupational English Test or IELTS and plan to take PLAB 1, eight have completed PLAB 2, five have applied for GMC registration and a further three are intending to apply. Six have now been granted registration and a licence, two have not yet applied to us despite being invited.

As of 27 March, there were 313 doctors with refugee status on our register with a licence to practise, and we had registered over 25 doctors with refugee status since the start of this year alone. We have signposted RefuAid to services that can assist those with registration in finding employment. Where there are applications in progress, we will move them forward without delay.

We also have a dedicated member of our international applications team who supports refugee doctors to gather evidence and they are working with several doctors to help progress their applications. We have been able to prioritise some refugee applications and grant full registration to those who were able to provide outstanding information.

We have carefully considered this group of doctors and concluded that there are significant risks in granting emergency registration to doctors who have not previously held registration without the routine checks that we usually apply at the point of registration. On average, about a third of candidates fail PLAB 2, therefore granting automatic registration for this groups would present some real patient safety risks if we were to put these doctors on to the temporary register without first having had those tests. We should also emphasise that we
needed to make decisions about where we can achieve the most valuable contribution to the pandemic. We concluded it was more effective to focus our efforts on the 35,000 or so that had formerly been registered and so had already demonstrated their ability to meet our standards.

In the meantime, these doctors can provide valuable help to our health services through roles that don't require registration. This includes working as medical support workers with NHS England which allows doctors who've passed an English language test to do some clinical tasks under supervision.

**Professional and Linguistic Assessments Board (PLAB 1) tests – international medical graduates**

The cancellation of the PLAB1 exam in Dubai on the 12 March 2020 impacted on 865 candidates. It is possible that there will be further venue closures for the exam due to be held worldwide on 25 June 2020. This will be dependent on in-country restrictions. We are working to extend future capacity for PLAB1 and ensure that these will function with appropriate ‘social distancing’ measures.

**Professional and Linguistic Assessments Board (PLAB 2) tests– international medical graduates**

Following advice from the UK government, all PLAB 2 tests from 18 March 2020 were cancelled, this may have affected up to 3,672 candidates. We recognise considerable inconvenience this may cause international doctors seeking to register to practice in the UK.

This has generated specific challenges for a small cohort of international doctors who have found themselves to be stranded in the UK. These doctors came to the UK to sit the PLAB 2 test and have since been unable to fly home. We are aware these doctors are being supported by associations representing BME doctors.

We have established measures to ensure that any IMG who had travelled to the UK for the PLAB 2 exam, which was then cancelled, and they then became stranded in the UK would be prioritised for an earlier exam date. This will allow them to travel home straight after their exam if travel restrictions have been lifted. It will also mean that some candidates can sit their exam before their visa expires.

We are hoping to restart PLAB 2 in July, although, of course we are continuing to monitor the situation. Assuming we will begin in July, we have ring-fenced three days in July for those doctors. Those doctors whose PLAB 2 date was cancelled have all received a full refund.

**Revalidation submission date change**

We have revised the revalidation date for doctors who were due to revalidate before the end of September 2020, the date will be moved back by one year. We've made this decision to
give responsible officers and doctors more time to reschedule and complete appraisals. We hope this will support the health service to prioritise clinical care for patients during the coronavirus pandemic.

As a result, 33,690 doctors will have been advised that their revalidation submission date has been revised as part of the pandemic response, regardless of their current licence status or any other factors. Our data shows that:

- 53.4% are male and 46.6% are female.
- 66.7% obtained their PMQ in the UK.
- 8.8% obtained their PMQ in an EEA country.
- 24.5% obtained their PMQ from a non-UK or EEA country

This breakdown reflects the general composition of the medical workforce and is the breakdown we would expect for year three in the five-year cycle. We are clear for all those in the cohort who have received a revised date that there is absolutely no negative inference to be drawn from these date change.

**Concerns about fair treatment**

Patients have the right to complain if they feel that a doctor has not treated them fairly or has discriminated against them. Although such complaints can be made at a local level, we will step in if a doctor poses a serious risk to patient safety or is likely to undermine public confidence in the medical profession.

At the current time, it is too soon into the pandemic to identify specific trends related specifically to allegations of discrimination based on protected grounds in the concerns that have been reported to us during the pandemic.

Looking at complaints received in March and so far into April, we have had 11 enquiries relating to 13 doctors with an allegation relating to fairness and discrimination – both towards patients and towards other doctors.

For context, during the same period in previous years we have had a similar number of enquiries and therefore we are not tracking a significant increase (although this may increase since there is lag between an enquiry coming in and it being triaged). We will monitor this as the pandemic continues.

**Doctors in training**

All doctors in training are being affected through redeployment, cancellation of the planned training rotations, elective procedures and cancellation of examinations. There is anxiety for trainees as we approach the Annual Review of Competence Progression decisions about their progression, especially for those in their final year of training who would be expecting to gain their CCT and join the specialist or GP register.
The GMC, four-nation statutory education bodies, Medical Royal Colleges and trainee organisations are working collaboratively to identify solutions to support doctors in training.

The impact on training appears to be varied by region and specialty. All doctors are affected by changes to planned training; however, it may be the case that some groups will be disproportionately impacted, such as BME and IMG doctors and those who are working less than full time.

There is an unexplained difference in the educational outcomes of BME doctors who have, on average a 12%-point lower pass rate in their specialty exams than white doctors. The difference is over 30% for doctors who obtained their primary medical qualification overseas.

Research into the cause of this differential attainment suggests that BME and IMG doctors can take longer to establish relationships when moving to a new training location which many of them will have done, are less likely to receive feedback on their performance or may feel less supported in a new environment which affects the quality of their learning experience and their ability to progress through critical points in training such as high-stakes examinations. The impact of the disruption to doctors in training during the Covid-19 outbreak may exacerbate existing differentials in experience and outcomes. We will monitor this data over the coming months.

**Safety of doctors**

We have heard discussion and speculation about the factors that might impact on the safety of doctors working during the pandemic. Some of this speculation has involved narratives on differences between the experiences of doctors. We have not received clear evidence of this, but has covered the following issues:

- Access to appropriately fitted personal protective equipment (PPE)
- Risks to pregnant women
- Mental health impact on doctors due to experiences working during the pandemic and worries about their own health
- Safety measures and the impact on certain groups. For example, guidance for Muslim doctors and other healthcare workers about shaving beards for PPE.
- Reasonable adjustments for doctors with disabilities using PPE
- Consistency and safety of advice on fasting during Ramadan for both patients and staff.

We have also been asked for clarification of the GMC’s position concerning doctors who are provided with inadequate PPE by their employing bodies and who may have concerns about working where patient contact is required. We understand the conflicting duties doctors are facing during the pandemic. Employers and government have a critical role in ensuring that
all healthcare professionals have the appropriate equipment to work safely. We note that responsibility at the start of the FAQs we have published on our website.

We cannot remove professional judgement from the environment in which doctors are caring for patients. Our role is to guide not replace individual ethical decision-making. It would not be right for us to set out how doctors should act in every circumstance they might encounter, as we are not privy to the particular circumstances the doctor faces at the time, they make their decision. We need to trust doctors to carry out risk assessments balancing the potential benefits for the patient with risks of harm.

In a crisis of this kind, decisions are being made every day at pace against a background of constantly emerging evidence and changing availability of resources. Our focus is on supporting flexible decision-making within the broad framework of our guidance.

May 2020

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5 https://www.gmc-uk.org/registration-and-licensing/temporary-registration/information-for-doctors-granted-temporary-registration/your-own-health