Written Evidence Submitted by the General Medical Council

(CLL0119)

Our role

1 The General Medical Council's (GMC) 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.

Overview

2 We welcome the Health and Social Care Committee and Science and Technology Committee's ongoing joint inquiry into the lessons learnt from the coronavirus (COVID-19) pandemic, which has tested the resilience of the health system and those who work in it. The fortitude of the workforce has been rightly lauded, with remarkable levels of public support.

3 The picture is complex but throughout the pandemic clear lessons have emerged and will continue to emerge. We owe it to doctors, and the patients that they care for, to learn from them. Addressing the inequalities that persist in medicine and across society has also been given a new urgency by the disproportionate toll of COVID-19 on Black and Minority Ethnic (BME) health and social care workers.

4 The pandemic has also demonstrated the importance of continuing to align the work of the different health and care regulators so that we have shared goals for improving the regulation and work environments of health and care professionals. For example, we aim to improve team-working and leadership within the workforce so that we can make its culture more supportive, inclusive and fair.

5 We also want medical regulation to be reformed so that we have the flexibility we need to respond at pace to the changing needs of doctors and patients. This will give patients better and safer care and will help us to retain and attract more professionals.

6 Our recommendations to the Committees are:

- Our emergency registration powers were vital for responding effectively to the pandemic. The Government's *Regulating healthcare professionals, protecting the public* consultation proposes all health and care regulators get emergency registration powers and we agree. The Committees should recommend that this proposal is included in future legislation to reform health and care professional regulators.

- For the Committees to recommend that the UK's health services are held to account for achieving inclusive working environments for healthcare professionals.

- For the Committees to encourage healthcare regulators and bodies to align their work to make work environments fairer, more inclusive and open.

- For the Committees to recommend that timescales and aspirations are set for the health care system to address workplace inequalities and embed robust measures and monitoring to understand the pace of progress being made.

- For the Committees to support healthcare regulators taking a stronger stance on ED&I issues, such as our ambitious targets of eliminating disproportionate fitness to practise referrals from employers, in relation to ethnicity and primary medical qualifications, by 2026. And to encourage all parts of the health system to support our target.

- For the Committees to support our target of eliminating discrimination, disadvantage and unfairness in undergraduate and postgraduate medical education and training by 2031. And to encourage all parts of the health system to support our target.

- For the Committees to support and endorse the recommendations of our three independent reports* and encourage our partners to continue working with us to implement them.

- That the Committees support the *Regulating healthcare professionals, protecting the public* consultation and our calls for reform of medical regulation.

- For the Committees to support and endorse the development of programmes to better prepare medical student graduates for being doctors, based on the evidence that the Foundation interim year 1 intervention (where graduating

* Independent review of gross negligence manslaughter and culpable homicide, Fair to refer?, Caring for doctors Caring for patients

medical students moved into roles in hospitals ahead of starting the foundation programme) supported the pandemic response and led to better preparedness.

- For the Committees to support training that supports doctors to be responsive to changes, such as those that emerged during the pandemic. This requires flexible training structures which continue to concentrate on generic skills, as well as specialisation throughout doctors' careers.

- That the Committees support changes which build on the changes to assessment in medical training during the pandemic, allowing trainees to demonstrate their capabilities in authentic real-life environments where possible.

- For the Committees to endorse the importance of continuing development of leadership skills throughout careers, recognising the importance of the contributions that doctors can make both inside and outside the health service.

- The Committees should recommend that the four UK governments, health services and departments continue to utilise and deploy doctors with temporary emergency registration, and encourage them to return to permanent registration and practice.

- It is also important that doctors can easily access or verify the information they need to prescribe safely. We encourage the Committees to explore whether current activity to improve access to patient information across health and care settings will remove remaining barriers, including between the independent sector and the NHS and across different health and social care organisations within the UK.

- We also invite the Committees to consider whether there are effective plans to monitor and evaluate the impact of telemedicine on patients and the healthcare workforce, and to ensure that the learning informs future health policy.

- The Committees should also recommend that healthcare services must be designed to allow for doctors to be able to offer the best methods of patient consultation, weighing up patient need and the advantages and risks of different options.

Our response to the pandemic

6 As part of the national response to the pandemic, between 26 March and 3 April 2020 we used our emergency powers to grant temporary emergency registration to 34,837 doctors that had previously relinquished their licence to practise. This

operated on an opt-out basis and as of 9 June 2021, there were 24,959 doctors with temporary registration.

7 We have also provided feedback to the Department for Health and Social Care (DHSC), the custodians of our governing legislation, about our emergency powers. We have recommended they give similar powers to the other healthcare professional regulators.

Regulating during the pandemic

8 At the start of the pandemic, we quickly issued a joint statement with the other professional health and care regulators* to reassure about how we would regulate during COVID-19. To further reassure doctors we also published new fitness to practise guidance in September last year for our staff who are decision-makers. This covered how to take the context created by COVID-19 into account when considering complaints about doctors.

9 We also took a more flexible approach to our fitness to practise processes to reduce incoming complaints, and those promoted to investigation and referred to Tribunal. Furthermore, we emphasised to Responsible Officers the importance of local resolution, so doctors didn't end up in our processes unnecessarily. At the height of the pandemic we also briefly paused disclosure of new investigations unless the individual was aware or an interim order was required to protect patient safety.

10 During the pandemic we also continued to run the Medical Practitioner Tribunal Service's† hearings virtually and in person. Furthermore, we deferred doctors' revalidation dates (the process doctors must complete to show their practice is up to date) to give them more time and flexibility to respond to the pandemic. Over a third of doctors during the peak of the pandemic still successfully revalidated ahead of their rescheduled date. We're still mindful of the pressures of the pandemic and we continue to support revalidation by providing doctors the flexibility they need to meet their local service needs.

Professional and Linguistic Assessment Board (PLAB) tests

11 In line with government guidelines we cancelled PLAB 1 and PLAB 2 assessments at the start of the pandemic. These are the tests we require doctors to take if they obtained their primary medical qualification from outside of the UK and EEA, to prove they have the appropriate knowledge and skills to practise safely in the UK.

* General Chiropractic Council, General Dental Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health and Care professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland, Scottish Social Services Council and Social Work England

† The tribunal service that's operationally separate from the GMC and makes independent decisions about doctors' fitness to practise

We have since been working with partners in the UK and abroad to resume both assessments.

12 The initial lockdown, the cancellation of the assessments and social distancing measures meant that our capacity to run PLAB was reduced. However, as soon as we could we restarted PLAB and we are building a new temporary Clinical Assessment Centre which will double our current capacity for testing overseas doctors who want to practise in the UK. Also, to mitigate the impact of cancelling PLAB tests we extended the validity of doctors' test passes. This means that for PLAB 1, if a doctor passed their assessment from 15 March 2018 onwards, we have extended the validity of the test pass from two to three years to give the doctors time to book onto PLAB 2.

13 The combination of these measures has meant that we have successfully been able to keep delivering PLAB when appropriate, albeit sometimes at a reduced capacity, to continue the flow of new doctors from abroad and into the UK throughout the pandemic.

Recommendation

14 Our emergency registration powers were vital for responding effectively to the pandemic. The Government's *Regulating healthcare professionals protecting the public consultation* proposes all health and care regulators get emergency registration powers too and we agree. The Committees should recommend that this proposal is included in future legislation to reform health and care professional regulators.

Impact of the pandemic on doctors

15 The UK needs to create a sustainable medical workforce to alleviate the pressures that existed before the pandemic and that have been exacerbated since. This requires recruiting, and more importantly retaining, more doctors by providing them with more support for their wellbeing.

16 To do this we must improve the culture within the UK's health services by making them just, open and inclusive. We must improve doctors' wellbeing and make their careers flexible and fulfilling. And it is crucial that the Government legislates to make medical regulation fit for the future.

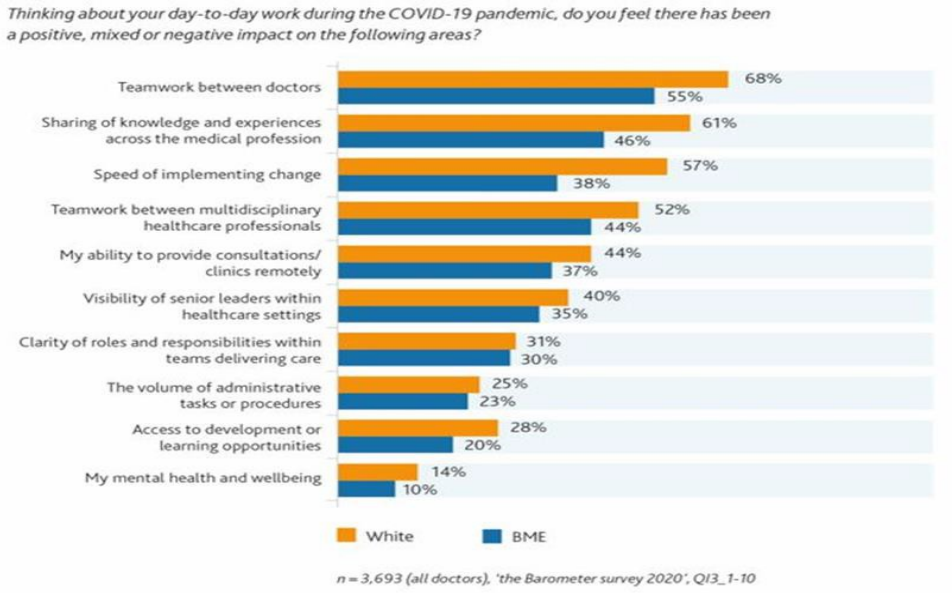
Our data on the impact of the pandemic

17 Our independent annual report, *The state of medical education and practice in the UK*, published last November, contains a wealth of data which supports our arguments about how to create a sustainable medical workforce. As you would expect, it said 2020 was a year of great change and impact on doctors' working

lives: 99% of doctors said they had experienced a change in their day to day work as a result of COVID-19, and 81% said their work had changed significantly.

18 Some of the change doctors experienced were positive. For example, 62% agreed that teamwork between doctors had improved, while 48% felt teamwork between multidisciplinary healthcare professionals improved. 54% felt that COVID-19 had a positive impact on knowledge sharing, and 49% on the speed of implementing change. The majority of doctors who perceived positive impacts also felt that they could be sustained beyond the pandemic. Such as, teamwork between doctors (70%) and multidisciplinary healthcare professionals (64%) and sharing knowledge and experiences (69%). It is vital that these positive changes are embedded in the future.

19 Despite these positive changes, doctors from a BME background were consistently less likely to have had a positive experience than their white colleagues. The chart below compares BME and white doctors' experiences, across ten aspects of their working lives. These findings are worrying as 38% of all licensed doctors in the UK are BME and this is growing. 61% of new doctors who joined the register in 2020 were BME, up from 42% in 2017.



Further data insights into doctors with a BME background

20 We also know from our data that BME doctors make up nearly two-thirds of specialty and associate specialist (SAS) and local employed (LE) doctors - a vital part of the workforce who make up the one in six UK doctors who are not GPs, consultants or in training roles. 30% of SAS doctors and 23% of LE doctors reported being bullied, undermined or harassed at work in the past year. Where bullying related to a protected characteristic, race was the most commonly cited factor.

21 According to our independent report, *Fair to Refer?*[*], we also know that employers are significantly more likely to refer BME doctors to the GMC for fitness to practise concerns, compared to their white peers. This is particularly important because a much higher proportion of employer referrals result in an investigation (77% versus 9% from the public).

22 There is also a gap between attainment levels of different groups of doctors across undergraduate and postgraduate training. For example, in postgraduate training, there's a 12% difference between exam pass rates for white and ethnic minority trainees who graduated in the UK. This rises to over 30% for overseas graduates. Local initiatives are underway to address underlying causes and we are encouraging organisations to evaluate how effectively these are supporting individual doctors. However, there has not been any improvement in pass rates at a UK level since 2015.

23 We believe that as a regulator it is incumbent upon us to provide strong leadership on these issues. Therefore, we have worked with our partners to improve induction, feedback and support for doctors new to the UK or NHS. We have also emphasised the need for engaged, compassionate and inclusive leadership across the NHS.

24 Our Chair, Dame Clare Marx, wrote a letter to doctors in June 2020 emphasising our commitment to ED&I and we have created ambitious new targets to hold ourselves accountable. These are:

- To eliminate disproportionate fitness to practise referrals from employers, in relation to ethnicity and primary medical qualifications, by 2026.

- To eliminate discrimination, disadvantage and unfairness in undergraduate and postgraduate medical education and training by 2031.

Data on doctors' wellbeing

25 Another challenge is doctors' wellbeing and burnout. *The state of medical education and practice* report found that 19% of doctors in 2020 felt unable to cope with their workload on at least a weekly basis. Whereas in 2019 28% of doctors felt unable to cope with their workload on a weekly basis. This suggests that during 2020 workload pressures have eased for at least some doctors, likely as a result of changes to their work during the pandemic.

26 However, it should be acknowledged that the positive reduction in doctor workload over the course of the pandemic may in reality reflect a detrimental impact on patient access to care, as elective procedures were postponed or cancelled. What

[*] Published 25 June 2019

we do know is that a significant proportion of doctors before, and during the pandemic, feel unable to cope with their workloads and this may continue after the pandemic.

Why doctors leave UK practice

27 We also surveyed (*Completing the picture*[*]) 13,158 doctors before the peak of the pandemic (between January and March 2020) about why they decided to stop practising or left the UK to practise elsewhere. The full survey results will be published later this year. But our early findings show that 90% of the doctors surveyed were abroad at the time of the survey and only 35% said they would like to return to practise in the UK. 27% said burnout and work-related stress was a factor in why they left UK practice and 35.7% said dissatisfaction with their previous role, place of work and NHS culture was a factor.

Creating a sustainable medical workforce

28 Our research and data create a complex picture that highlights the positive and negative impacts of the pandemic on doctors and the different challenges of creating a sustainable medical workforce. We know that for some doctors workplace culture is not good enough, that some are still discriminated against, and that they need more flexibility in their working lives and for their wellbeing to be prioritised. We also know that doctors are resilient and that even in these exceptional circumstances they have improved their team-working and knowledge sharing and are hopeful about maintaining these positive changes.

29 We have already begun work to address the challenges we have identified after commissioning three independent reports: *Fair to Refer?* *Gross negligence manslaughter and culpable homicide* and *Caring for doctors Caring for patients*. These each contain recommendations that focus on equality, diversity and inclusion; leadership and support; and wellbeing of the medical workforce. We have been working with our partners in the four countries to implement these recommendations. We have adapted them to reflect the impact of COVID-19 as we believe they will still help address the issues highlighted by the pandemic.

Recommendations

30 For the Committees to recommend that the UK's health services are held to account for achieving inclusive working environments for healthcare professionals.

[*] Conducted in partnership with Health Education England, the Department of Health Northern Ireland, NHS Education for Scotland and Health Education and Improvement Wales

31 For the Committees to recommend that timescales and aspirations are set for the health care system to address workplace inequalities and embed robust measures and monitoring to understand the pace of progress being made.

32 For the Committees to support healthcare regulators talking a stronger stance on these issues, such as our ambitious targets of eliminating disproportionate fitness to practise referrals from employers, in relation to ethnicity and primary medical qualifications, by 2026. And to encourage all parts of the health system to support our target.

33 For the Committees to support our target of eliminating discrimination, disadvantage and unfairness in undergraduate and postgraduate medical education and training by 2031. And to encourage all parts of the health system to support our target.

34 For the Committees to support and endorse the recommendations of our three independent reports and encourage our partners to continue working with us to implement them.

35 For the Committees to encourage healthcare regulators and bodies to align their work to make work environments fairer, more inclusive and open.

Reforming medical regulation

36 It has also become clearer during the pandemic that the need for reform of medical regulation is greater than ever, so that we can retain the flexibility that has allowed us to respond effectively to the pandemic. That's why we wholeheartedly welcomed the Government's consultation, *Regulating healthcare professionals, protecting the public*, as the first step towards improving regulation of doctors and patient safety.

Ensure fitness to practise cases are fast, few and fair

37 Fitness to practise is a vital part of our work to protect public safety but prescriptive legislation makes the process too cumbersome. For example, we have no choice but to open investigations we think are unnecessary and the process is long and inflexible. Investigations can also be stressful for doctors and complainants.

38 Reforming this process by giving us a discretion to investigate rather than a duty would mean we could have fewer unnecessary investigations. And having a more flexible process would allow us to conclude investigations quicker. This would free up our resources to focus on the highest risk cases and to focus on preventing poor practice before it happens. This would help create a more just culture in the medical workforce by allowing us to better support doctors to learn from their mistakes.

Attracting more senior doctors to the UK

39 The UK is a popular career destination for senior specialist and GP international doctors from outside of the EEA. And they are sorely needed to fill the vacancies in the UK's medical workforce. However, our legislative process for recruiting these doctors is prescriptive, bureaucratic and burdensome. It requires these doctors to provide around 2,000 pages of information and spend around nine months gathering evidence to apply to practise in the UK. Even then only half are approved.

40 We need reform to grant us more autonomy over the specialist and GP registration process, to create a more flexible approach to assess doctors' capabilities and reduce the bureaucratic burden. It would also benefit existing senior staff and associate doctors (who are mainly from a BME background or who hold an international medical graduate qualification) in the UK looking to progress their careers. This has Government and cross-party support in Parliament.

Recommendation

41 That the Committees support the *Regulating healthcare professionals, protecting the public* consultation and our calls for reform of medical regulation.

Medical education and training

42 Last year we engaged with a wide range of stakeholders, culminating in an Education Summit with system leaders. During this we discussed how we must balance services without losing sight of training and work across the health systems to manage the pipeline of medical trainees to ensure they are able to build knowledge and skills to meet the high standards we require. The pandemic has given us pause to think differently about how we do this and created real opportunities to bring in meaningful changes to medical education and training. So that we can broaden access to medicine, make education and training more flexible and relevant to doctors' careers, and resilient in times of crisis.

43 For example, in 2020 we believe graduating medical students were better prepared for Foundation Year 1 (their first year as a doctor working in the health service) by the *Foundation interim Year 1* intervention (the programme we used to better prepare medical students for their first year as a doctor). We want to continue and expand the support for medical students as they prepare for their first jobs. We also want these interventions to be flexible and adaptable to the needs of the UK's four countries, and to the specific roles medical graduates have at Foundation Year 1.

44 Patients also benefit significantly when doctors combine generalist and specialist skills and capabilities. During the pandemic many doctors combined these skills by working across teams, specialties and work contexts. Learning from this, we need

flexible structures that give doctors both the specialist skills they need and the foundation to adapt and learn, in order to get the right balance of skills to meet service and patient needs as they emerge throughout their careers. We also want doctors to be able to enhance their balance of skills throughout their whole careers.

45 Changes to specialty curricula, college examinations, progression and other assessments have been simplified to help doctors move through training despite the disruption caused by the pandemic. In many cases, this has streamlined curricular outcomes and requirements, including reducing the number of assessments and changing their format. These changes will help to manage training through the next potential wave of COVID-19 and ensure we manage progression fairly in the short-term. We are also seeing if these changes could be beneficial in the long-term once the pandemic subsides.

46 The crisis has also shown the influence that doctors can have in promoting practical, preventative public health. The importance of this leadership and collaboration, both inside and outside work environments, should be built upon with training, support and tools available to help doctors to promote broader health literacy and wellbeing, including public, preventative and community health in the variety of UK communities throughout their careers.

Recommendations

47 For the Committees to support and endorse the development of programmes to better prepare medical student graduates for being doctors, based on the evidence that the *Foundation interim year 1 intervention*, where graduating medical students moved into roles in hospitals ahead of starting the foundation programme, supported the pandemic response and led to better preparedness.

48 For the Committees to support training that supports doctors to be responsive to changes, such as those that emerged during the pandemic. This requires flexible training structures which continue to concentrate on generic skills as well as specialisation throughout doctors' careers.

49 That the Committees support changes which build on the changes to assessment in medical training during the pandemic, allowing trainees to demonstrate their capabilities in authentic environments where possible.

50 For the Committees to endorse the importance of continuing development of leadership skills throughout careers, recognising the importance of the contributions that doctors can make both inside and outside the health service.

Government communications and public health messaging

Temporary registration

51 We have worked closely with governments, officials and health services in the UK's four countries to help them give doctors with temporary registration the information they need. For example, we signposted these doctors to content hosted by health services in England, Northern Ireland, Scotland and Wales about deployment and terms and conditions. We also pointed doctors to a survey run by NHS England and Improvement which allowed them to indicate whether they were able to support the pandemic response.

52 As the UK-wide regulator of doctors, we have provided doctors with temporary and permanent registration, advice about their practice and wellbeing. For example, we provided FAQs about the pandemic on our online Ethical hub, including on potentially difficult issues such as vaccines and kept them up to date on things like our new *Decision making and consent* guidance.

Deployment

53 In late 2020 we conducted a survey of doctors with temporary emergency registration. This will allow us to remove those individuals who do not wish to return to practice, and support those that do. So far, we've found that 3,000 doctors are prepared to come back, and more than 1,800 said they would consider returning to permanent registration. This survey was also completed before approved vaccines were announced and the beginning of the vaccination programme. Since then, more doctors have opted in for temporary emergency registration.

54 There is a huge opportunity to encourage more of these doctors to return to permanent registration and practice.

Recommendation

55 The Committees should recommend that the four UK governments, health services and departments, continue to utilise and deploy doctors with temporary emergency registration, and encourage them to return to permanent registration and practice.

Remote consultations

56 The use of telemedicine and remote consultations strongly increased during the pandemic and played a significant role in the pandemic response by lowering footfall in GP surgeries which reduced the potential of virus transmission. There may also be other benefits, such as improved or more convenient access for patients of all ages, disabled patients and those with long term conditions.

57 However, we have some concerns, such as the potential for increased prescribing of antibiotics and the risk of missed diagnoses, including cancer. And as the role of telemedicine and remote consultations grows, so does the need to ensure equity of access to technology for everyone including those who are socio-economically disadvantaged, those who require access to interpretation services and people who struggle with computer technology.

58 We recognised the challenges associated with remote consultations and prescribing before the pandemic and how these issues have become more salient since. Therefore, we have created a suite of materials to support patients and doctors. Such as, a set of principles* (2019) for all health professionals undertaking remote consultations and prescribing. A Q&A for doctors consulting and prescribing remotely during the pandemic. A set of co-produced† safety tips for patients accessing healthcare online. And more recently, we have published updated guidance for doctors on remote consultations and prescribing.

59 It is also vital that doctors are able to access a patient's medical history, especially when prescribing controlled drugs which present a risk of addiction, misuse or overuse. The pandemic has expedited changes to improve information sharing within the NHS and with the independent sector, but there are still gaps. We know doctors in both remote and face-to-face settings will sometimes find themselves in a position where they cannot easily access or verify the information they need to prescribe safely. In England, we are aware that NHSX is developing a 'Tech Plan for Health and Care', which is looking at how all those involved in the delivery of care can access the information they need. We hope this will be an opportunity to remove barriers for doctors and other healthcare professionals when accessing relevant patient information.

Recommendations

60 It is important that doctors can easily access or verify the information they need to prescribe safely. We encourage the Committees to explore whether current activity to improve access to patient information across health and care settings will remove remaining barriers, including between the independent sector and the NHS and across different health and social care organisations within the UK.

* Co-authored by the Academy of Medical Royal Colleges, Care Quality Commission, Faculty of Pain Medicine, General Dental Council, General Optical Council, General Pharmaceutical Council, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland, Royal Pharmaceutical Society, Regulation and Quality Improvement Authority

† Care Quality Commission, Healthcare Improvement Scotland, General Pharmaceutical Council, Nursing and Midwifery Council, Pharmaceutical Society Northern Ireland, Royal Pharmaceutical Society, Medicines & Healthcare products Regulatory Agency, Healthcare Inspectorate Wales

61 We also invite the Committees to consider whether there are effective plans to monitor and evaluate the impact of telemedicine on patients and the healthcare workforce, and to ensure that the learning informs future health policy.

62 The Committees should also recommend that healthcare services must be designed to allow for doctors to be able to offer the best method of consultation, weighing up patient need and the advantages and risks of different options.

(June 2021)