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Opinion Article

The Graduation of Medical Students who Lack the Necessary Skills and Behavioural Attributes to Practise Medicine Safely – Contrasting Approaches to this Problem in The USA and The UK

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Abstract

It is well recognised that medical schools permit students to graduate, knowing that one or two (or possibly more) of these new doctors are unsuitable to enter clinical practice. Well aware of the academic limitations or unprofessional behaviour of unsuitable individuals, nevertheless medical schools sometimes allow them to become doctors. This paper contrasts the UK and USA approaches to this problem. In both countries there is a general reluctance to report and address the adverse behaviours exhibited by a subset of students. Both countries have systems to provide the possibility of remediation. The UK has the advantage of medical regulation at a national level by the General Medical Council (GMC). This facilitates the management of significant student problems by individual medical schools, each of which operate a fitness to practise committee, a framework with which to make fair decisions regarding interventions which in severe cases can comprise suspension or termination of studies. The GMC itself operates a system that scrutinises all newly qualified doctors, who have to apply for provisional registration, in order to detect and halt the progress of a small subset (in the UK there were 10 in 2019) where there was insufficient evidence to demonstrate fitness to practise. Those whose career is halted by the GMC are provided with detailed information about the reasons for the decision and the types of change that would need to be demonstrated if the doctor wishes to re-apply for provisional registration, and remediation is possible. Published data shows that every single doctor refused provisional registration had demonstrated both a lack of insight and a failure to demonstrate remediation, inabilities which must be overcome if the doctor is to gain provisional registration and be permitted to enter clinical practice. The USA lacks a national regulator for the medical profession, and is arguably less well equipped to tackle medical students and newly qualified doctors who have exhibited extremes of adverse behaviour.

Keywords: Fitness to practise; Unprofessional behaviour; Termination of studies; Remediation; Insight

Introduction

Permitting an unsuitable student to qualify as a doctor

It is well recognised that deans of medical schools permit students to graduate, knowing in their hearts that there are one or two (or possibly more) of these new doctors whom they would not allow to care for their family. Well aware of the academic limitations or unprofessional behaviour of unsuitable individuals, nevertheless medical schools sometimes allow them to become doctors, recently described as “kicking the can down the road” [1]. The background to this most unsatisfactory state of affairs is the very widespread, well-documented and long-standing history of awarding passing grades to failing health and social care students coupled with unwillingness to record negative evaluations of students [2].

One argument for the detection and intervention when medical students exhibit unprofessional behaviour is the evidence that if such students are allowed to graduate as doctors there is an increased risk of them going on to become disruptive or incompetent clinicians [3-6]. It is notable that the reluctance to recognise unprofessional behaviour is not confined to undergraduate education. Studies of “doctors in difficulty”, a term used to describe postgraduate medical trainees in the UK with problem behaviours, estimated to apply to 6.5% trainees, have shown a similar under-reporting of concerns, a lack of negative feedback, and poor quality of completion of work-based assessments [7].

Graduating incompetent or disordered medical students betrays our social contract with society, our colleagues, and our profession. The aim of this paper is to contrast the different approaches used to respond to the problem in the USA and the UK.

Graduation cannot be guaranteed for every medical student

The simple fact is that it is unlikely that every single student who starts medical school should be allowed graduate as doctors, and similarly it is unlikely that every student who is required to overcome and remediate their behaviour problems can be helped to do so.

The national data made available by the Association of American Medical Colleges (AAMC) is not specific to individual education providers [8]. The situation is complex in the USA, where there are least 6 different categories of medical degree programmes, MD only, Bachelor's-MD programmes, MD-MBA programmes, MD-MPH programmes, MD-PhD programmes and MD programmes combined with other programmes. Figures for expulsion are not available, but the AAMC have published the differing attrition rates for each of the 6 programmes, divided into attrition for academic reasons and attrition for nonacademic reasons. Attrition rates vary by category of MD degree programme. Students in MD-MBA combined degree programmes had the lowest attrition rate (0.3%), and students in combined bachelor's-MD programmes had the highest attrition rate (5.2%). Currently, only 3.3% of medical students fail to graduate from medical school [8].

UK data for medical student attrition is available from the Higher Education Statistics Agency (HESA) at www.hesa.ac.uk. This shows that for medical students entering between the years 2002 and 2013 (some UK medical degree programmes take 6 years), between 91% to 93% successfully completed the programme.

In other countries, far higher medical school failure rates have been reported, for example 17% in the Netherlands, 18% in India, 21% in Italy, and 60% in Iran [9]. However these figures are not up to date. Comparison of different national rates is complicated by numerous factors, one of which is whether or not selection processes limit the number of students enrolling in a medical school. So, for example, the number of those entering medical school in the UK is restricted, with considerable competition for entry, whereas in some other countries restricting entry to medical school is impermissible and instead most students are eliminated through examinations early in the programme.

Graduation of unsuitable students in other professions

This article is about the graduation of unsuitable medical students, but it would be wrong to create a false impression that this problem is confined to the medical profession. A number of studies have indicated a failure to recognise and tackle similar problems is seen in some students of dentistry, nursing, midwifery, physiotherapy, occupational therapy, other health professionals, as well as social work, teaching, and accountancy [2].

Suggested solution from the USA

A suggested solution that has recently come from the USA is the creation of so-called "off-ramps", points along the educational continuum at which students can reassess their goals and educators can assess competence, that allow students to leave medical school [10,11]. Whilst this may or may not be a new idea in the USA, it has been standard in the UK for medical school curricula to provide opportunities for exit at various points along the way, either by transferring to other programmes or by exiting with a non-clinical science degree, in addition to there being mechanisms for termination of studies resulting from non-attendance, assessment failure, or unprofessional behaviour. Whilst the mechanisms for a "gentle" exit exist in the UK, seriously struggling students are commonly effectively crippled by a lack of insight, which prevents their acceptance of alternatives to trying to graduate even in the face of hopeless difficulties.

The UK solution – scrutiny of newly qualified doctors by General Medical Council

The position in the UK is that despite a great deal of advice and guidance from the UK national medical regulator, the General Medical Council (GMC) [12-14], and despite there being a clear requirement that medical schools should only permit the graduation of individuals who are fit to practise medicine, medical schools cannot be relied upon to ensure that all newly qualified medical students are indeed fit to practise.

In the UK, having passed their medical school or university final examinations and obtained a medical degree, in order to commence their clinical career newly qualified doctors must first apply for, and be granted, provisional registration with the GMC. In 2019, the most recent year for which data is available, the GMC received 7408 applications for provisional registration from UK graduates [15]. In order to assess whether applicants are fit to practise medicine, they are required to declare matters relating to their character and conduct, and their health, and 984 (13.3%) of the 7408 applicants declared one or more fitness to practise issues. Of these 984 applicants who declared an issue, 158 applications triggered an investigation by the GMC Registration Investigation team. Applications were usually referred to this team because they had more serious or complex issues that warranted further information being collected before a decision about an applicant's fitness to practise could be made.

Of the 7408 applications for provisional registration, 7340 were granted, 58 applicants withdrew their applications or had them closed, either because they did not want to proceed or because they were ineligible, for example due to a late decision to take time out before commencing a clinical career. However, there were 10 applicants whose application was refused.

Those refused provisional registration have three choices. The first is to decide to abandon a medical career, maybe based on a realisation that it would be difficult to overcome the deficiencies that have been identified, or based upon a preference to pursue another career. The second is to appeal against the refusal. The third and most common option is to re-apply. Whilst re-application is permissible at any time, the re-application needs to show how the various problems identified by the GMC have been addressed and overcome. In the years 2010-2019 there have been 49 refusals, and of these 17 successfully re-applied (plus three who successfully appealed against refusal). In practice those who have been refused provisional registration are likely to face the loss of at least one year of their medical career, in part because entry to the two year mandatory national training programme for newly qualified doctors in the UK is usually only possible once a year, on 1 August.

Reasons for refusal to grant General Medical Council provisional registration

Some applicants had more than one reason for refusal, and the issues were in three categories, criminal behaviour (17 issues), professional misconduct (60 issues) and health (37 issues). In only four of the 49 refusals was health the sole reason for refusal, for example because of the seriousness of the health problem, failure to provide evidence of sustained abstinence from alcohol or of engagement and compliance with an appropriate support programme, or persistence of mental health issues coupled with impulsiveness and alcohol use.

Regarding the criminal behaviour, the crimes involved violence in 5, theft in 2, being drunk and disorderly in 2, drug related in 2, criminal damage in 2, deception in 1, fraud in 1, speeding in 1, and drink driving in 1.

Regarding professional misconduct, the behaviours were labelled as misconduct in 39, attendance problems in 11, probity in 5, academic performance issues in 4, and deficient professional performance in 1.

Regarding health, the problems were depression in 11, stress and anxiety in 8, alcohol or drug dependency in 6, psychosis, hearing voices and schizophrenia in 2, mania or bipolar disorder in 1, attempted suicide and self-harm in 1, borderline personality disorder in 1, other mental health problems in 2, and physical problems in 5. It is important to note that adverse physical or mental health alone is not usually sufficient to conclude there is impairment of fitness to practise. The reasons why an applicant's fitness to practise in regards to health may be a concern are:

- failure to seek appropriate advice or treatment from an independent and appropriately qualified healthcare professional;
- refusal to follow medical advice or care plans, or refusal to comply with arrangements for monitoring and reviews of health matters;
- failure to recognise limits and abilities or lack of insight into health concerns;
- failure to comply with reasonable adjustments (special provisions put in place for disabled students) to ensure patient safety; or
- failure to be immunised against common serious communicable diseases (unless contraindication).

The importance of insight and remediation

The GMC regards insight and remediation as being particularly important in cases where fitness to practise appears to be impaired, whether in medical students [16, 17] or registered doctors in practise. Thus lack of insight and failure to provide evidence of remediation were both given as reasons for refusal in all 49 graduates who were refused provisional registration.

Insight is crucial because the inability to recognise one's own errors makes it difficult to make the necessary corrections to behaviour. Remediation, a difficult concept, means taking steps to addresses concerns about knowledge, skills, conduct or behaviour.

There is an element of controversy about insight and remediation. It has been argued that the demonstration of insight and remediation may be no more than a sham, arguing that it may be little more than a 'contrived exchange of remorse, insight and remediation' [18]. The implication is that students applying for provisional registration need to provide evidence that their apparent insight and remediation are genuine changes that have been achieved.

Students who have a continued need for high levels of support

UK medical schools are expected to provide support for medical students in line with GMC guidance. However, the GMC has indicated that students need to be able to demonstrate that they can manage with reducing levels of support towards graduation. This means that a student who despite repeated warnings has a continuing need for what one might call educational "intensive care" (such as students who fail to attend appointments or scheduled activities, respond to email communications from the medical school, or accomplish important tasks unless they are given daily reminders) risks being refused provisional registration. As with children learning to ride a bicycle or learning to swim, to be able to demonstrate proficiency they need to be able to ride a bicycle without stabilisers or swim without flotation devices.

The relevance of student fitness to practise procedures

All medical schools have a mechanism to deal with students whose behaviour seriously departs from that which is expected for future doctors. Ultimately, in particularly serious cases, all medical schools have policies, procedures and powers to terminate the studies of a student whose behaviour is regarded as being fundamentally incompatible with a medical career. Each country has different names for such procedures. In the UK, Ireland, Australia, New Zealand and Canada, the term "fitness to practise" is applied to procedures that consider a student's professional suitability. Whatever the name given to the decision-making process or committee, the common feature is that the committee has the power to terminate (or recommend termination) of studies, a drastic outcome that is usually reserved for the most serious cases [13,19]. The aim of this type of process is to ensure that decisions are fair, and offer students a full opportunity to respond to criticisms and concerns. The principles of fairness, sometimes referred to as "natural justice", have been set out in some detail [20-22]. The fundamental components are (i) that the decision makers are neutral and independent of the education programme and the student, and have no vested interest in the outcome, and (ii) a process is followed in which one or more clear allegations and supporting evidence are shared with the student and a representative of the education programme sets out the case against the student, and the student is given a full opportunity to respond to any concerns and criticisms.

Each medical school in the UK has a fitness to practise committee to consider cases of severe difficulties with student behaviour where the suitability for a future medical career has been questioned [23,24]. Thus in 2017, the most recent year for which there is published data, of 40,997 UK medical students attending 36 medical schools, 125 had to attend their medical school's fitness to practise committee, and 17 were expelled [25].

If each UK medical school has special procedures to deal with students who exhibit severe behaviour problems, how do 'bad apples' nevertheless proceed to graduation, only be caught by the GMC provisional registration process? Possible explanations are:

- The medical school procedures (and any subsequent university appeal procedures) failed adequately to deal with individual students;
- The GMC incorrectly refused to grant provisional registration in one or more cases. The GMC approach differs markedly from that used by medical schools. The GMC method is a paper exercise, whereas in medical school fitness to practise cases the student meets, and can be interviewed by, a decision making panel, as part of an adversarial process in which a medical school representative sets out the case against the student and the student (accompanied by a representative) responds; or
- New or very recent matters. These could be recent criminal offences, possibly unreported to the medical school, or disclosures made by the student during the registration application process.

Discussion

In the absence of any directly comparable data, it is hard to say whether in terms of assuring the quality of medical graduates the US systems or the UK ones are the more effective. Each has its merits, of which the key one is that both provide for the possibility that a defective graduate will still have an opportunity to overcome their difficulties and have a productive medical career. The advantage of the UK system is that the involvement of the national healthcare regulator, the General Medical Council, whilst halting the progress of a small number of individuals, in its refusal decision letters provides a detailed analysis and a clear steer as to what the individual will need to do for their career to continue. In comparison, the US system, lacks a national healthcare regulator and does not posses quite the same 'teeth', although individual US medical schools do have systems and due processes to enable expulsion of students, though fear of litigation is well known to be an important deterrent to halting progression or expulsion.

In contrast to the UK, where national data is collected and published by the GMC, there is no national medical regulator in the USA to publish equivalent data.

The essential component of systems leading to expulsion is comprehensive documentation. This is needed to convey students' deficiencies, justify grades, provide clear warnings, and set out necessary remedial actions. Education providers need to be prepared to defend their professional judgements, for which detailed documentation is essential.

It is extraordinary that medical schools continue to permit unsuitable students to graduate as doctors. The UK system run by the GMC has the advantage of being a national strategy to protect the public from unsuitable newly qualified doctors. However, whilst the present system UK successfully protects the public from demonstrably unsuitable newly qualified doctors, it is not known how many unsuitable doctors are undetected. At present each medical school has its own systems for assessing students at the end of their undergraduate studies, with the risk that each applies differing standards. To address that problem, the GMC is introducing a national Medical Licensing Assessment (MLA), and UK medical students graduating in the academic year 2024-25 will need to pass the MLA as part of their medical school degree, before they can join the Medical Register. The USA also has a "United States Medical Licensing Examination" (USMLE). This is a three-step examination for medical licensure in the United States and is sponsored by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME). It is a test of knowledge and skills. However neither of these licensing examinations is designed to detect the types of unprofessional behaviour that can render newly qualified doctors unsuitable to enter clinical practise.

Legal representation of students is widely perceived as a threat by education providers. One advantage of the arrangements in the UK is that medical and dental students attending a UK medical school receive free membership of medical defence organisations such as the Medical Defence Union, the Medical Protection Society, or the Medical and Dental Defence Union of Scotland. Similar support is available to pharmacy students from the Pharmacists' Defence Association. Student membership entitles students to free support, legal advice and representation when dealing with serious disciplinary matters such a fitness to practise committee. One of the little known benefits of which there have been some very striking examples at the University of Manchester, is that on some occasions a medical defence society has been able to completely turn around the unstoppable downhill trajectory of a hitherto quite unmanageable medical student heading for expulsion who has been entirely resistant to support, advice and the most dire warnings. Why a student who is seen as unmanageable by a medical school should favourably respond to the advice of a medico-legal adviser is not known, but it may be no more complex than the reason why children may respond favourably to a complete outsider having failed to follow the advice of their parents.

It is always possible that a perfectly sound newly qualified doctor could go off the rails after graduation. However, the UK, the USA and most other countries have systems of healthcare regulation that enable the public to be protected from such individuals.

Conclusions

It is a fact that medical schools permit a number of unsuitable students to qualify as doctors. This appears to be due to reluctance to report and act upon lapses of professional behaviour. Publications sometimes describe this reluctance in graphic terms. One described those reluctant to report adverse behaviours as "silent witnesses". Another, referring to reluctance to report underperforming students, said "you don't want to sort of be the one who sticks the knife in them".

Conventional assessment processes, such as examinations that test knowledge and skills, may not be good at detecting problems with an individual's attitude and behaviour. If the public are to be protected there needs to be detailed documentation of problem student behaviours at the

time they occur, coupled with having a method to process and act upon this information. In the UK each medical school has a "fitness to practise" committee to deal with such problems, and in extreme cases the committee has the power to terminate the studies of a student. The work of these committees is informed by guidance from the GMC, the national regulator for doctors. This is coupled with a system at graduation whereby the GMC scrutinises the aspects of the behaviour of all newly qualified doctors, enabling the GMC to identify a small number who are not permitted to enter clinical practice. Thus in the UK there are two levels of systems designed to ensure that newly qualified doctors are safe to enter clinical practice. Data from both levels is collected and published by the GMC. In contrast, USA medical schools usually have the power to expel students, however the arrangements vary greatly from school to school, there is no national regulatory guidance to govern these processes, and there is no system to collect and publish national data concerning expulsions of students. There is also no second level national system to screen all newly qualified doctors, in part because in the USA the system of medical regulation is managed at a state level and there is no national medical regulator.

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