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Fitness to Practise, A Framework to Aid Assessment of Professional Suitability of Medical Students and Newly Qualified Doctors in the UK. The Positive Influence of the National Medical Regulator, the General Medical Council

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Abstract

The over-arching objective of the regulation of doctors in the UK comprises the protection, promotion and maintenance of the health, safety and well-being of the public, the promotion and maintenance of public confidence in the medical profession, and the promotion and maintenance of proper professional standards and conduct for members of the medical profession. These three components are sometimes referred to as the "public interest". The UK has a national regulator of the medical profession, the General Medical Council (GMC). As well as controlling entry to, and exit from, the Medical Register, a list of all doctors permitted to practise medicine in the UK, the GMC maintains an important oversight of both undergraduate and postgraduate medical education in the UK. This paper describes the processes in place, all heavily influenced by the GMC, to ensure the professional suitability and fitness to practise of all newly qualified doctors in the UK. There are many components to the input of the GMC, but of central importance are the arrangements for the assessment and management (by universities) of the fitness to practise of medical students and the assessment by the GMC of the fitness to practise of all newly qualified doctors.

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

Introduction

The aim of this paper is to describe the efforts made in the UK to ensure that medical students and newly qualified doctors are suitable to enter the medical profession. We have previously described the alarming fact that sometimes medical students who lack the necessary skills and behavioural attributes to practise medicine safely are permitted to graduate and enter medical practice [1]. In the USA, the fact that unsatisfactory students are sometimes allowed to become doctors despite senior staff being well aware of their deficiencies was described in the New England Journal of Medicine by Santen et al as "kicking the can down the road" [2]. This followed the disclosure in another prominent medical journal, the Journal of the American Medical Association, that although one third of USA adults have hypertension, only 1 out of 159 medical students from medical schools in 37 USA states correctly performed all 11 elements in a blood pressure check using simulated patients, and the average number of steps performed properly was an abysmal 4.1 [3]. Santen et al concluded that "it's essential to honestly acknowledge when a student will not live up to our professional values and competencies" and recommended the creation of "off-ramps" and the making of "some tough decisions". An off-ramp is a sloping one-way road leading off a main highway, and the combination of "off-ramps" and "tough decisions" may be regarded as a euphemism for termination of studies, a strong disincentive (particularly in the USA) being a fear of legal action against the education provider [2].

The evolution of the national regulation of doctors in the UK

Before 1815, the main route to medical practice in the UK was the successful completion of an apprenticeship, which was all that was needed for entry into medical practice. Prior to 1858, the state of medical practice in the UK was chaotic [4-6]. There were 19 separate licensing bodies, and they conferred professional titles after very differing tests. Most physicians knew little surgery and few surgeons knew much medicine; indeed surgeons could be penalised for prescribing medicines. Most of the titles conferred had a purely local value with the result that, for example an Edinburgh practitioner might be unable to practice in London or Glasgow. There was no register of qualified practitioners, nor were there any legal definitions of "qualified practitioners". The 1841 census had revealed that of the 15,000 doctors in the UK, 5,000 were not qualified. In short, at that time there was no single way of knowing who was a qualified doctor in the UK (including Ireland at that time) and who was not.

That remained the position until the Medical Act of 1858 received Royal Assent, after 18 years of parliamentary debate, and no fewer than 17 earlier attempts to introduce such an act, from 1840 onwards. The 1858 Act was described as "an Act to regulate the qualifications of practitioners in medicine and surgery". Its purpose was to enable "persons requiring medical aid … to distinguish qualified from unqualified practitioners". The Act established the General Medical Education and Registration Council of the United Kingdom. This name was shortened to General Medical Council (GMC) in 1951 [7].

Initially, the GMC could not specify a curriculum for medical education, and in this area its powers were limited to examining the curriculum of a licensing body and deciding whether it was "sufficient" or "insufficient" for the purposes of registration. With the Medical Act 1886, the GMC's powers were strengthened, and for the first time applicants had to have passed examinations in medicine, surgery and midwifery.

Often regarded as inferior to a medical qualification obtained from a university, the Royal College of Surgeons of England teamed up with the Royal College of Physicians of London, and the former paired their Membership (MRCS) with the latter's Licentiate diploma (LRCP), thus creating the Conjoint Diploma, a basic medical qualification, until this ceased to be available in 1999. Similar conjoint diplomas were available from the Royal Colleges in Edinburgh, Glasgow, and Ireland. The examinations for a conjoint diploma were taken by some UK medical students, sometimes because they had failed to obtain their primary medical qualification from the university where they had studied. Another reason was because students were permitted to sit the conjoint exams before they were able to sit their own university exams, so obtaining the conjoint diploma could mean earlier GMC registration which enabled them to start work as a doctor and earn money sooner.

From 1953, newly qualified doctors in the UK were required to undertake a minimum of 12 months satisfactory service in approved hospitals in what was named from the 1990s a "Pre Registration House Officer" year before they could apply for full GMC registration [8]. Initially, six months had to be in medicine and six in surgery, with not more than six months in midwifery to count towards either.

From 2005, newly qualified doctors had to enter a two-year Foundation Programme in approved hospitals, and this was designed to give trainees broad general experience before choosing an area of medicine in which to specialise. In the first year, F1, doctors only have provisional GMC registration, but upon satisfactory completion of the F1 year they receive full GMC registration.

An additional route to obtaining a medical qualification and practising as a doctor was provided by the Society of Apothecaries of London [9-11]. The apothecary of the medieval City of London kept a store of spices, herbs and drugs which he compounded, dispensed and sold from his shop or stall. Initially described as a spicer, the apothecary came to be known as such towards the end of the thirteenth century. In modern terms the medieval spicer-apothecary was a pharmacist [10]. The Society did not run a medical course, but it had the right to set qualifying medical examinations under a Royal Charter granted by King James I in 1617. The Society was dedicated to training apprentices in the art of the apothecary, ensuring that medicines made and sold by its members were genuine, punishing frauds, and raising standards among London apothecaries generally. The educational role of the Society expanded when under the Apothecaries Act of 1815 it became an examining body for the medical profession and could awarded the Licence in Medicine and Surgery of the Society of Apothecaries (LMSSA), and thus (in effect) deciding the content of basic medical education. However, the LMSSA came to be regarded by some [12, 13] though not all [14, 15], as an inferior qualification, serving as a loophole for unfit medical students. The limited evidence for the concern was based on the fact that in December 1982, 10 final year clinical medical students at Cambridge failed their qualifying examinations; eight immediately chose to sit the LMSSA examination and seven passed the four parts of the examination straight away [13]. The Society ceased to license doctors in 1999.

Finally, since 1533, the Archbishop of Canterbury could confer the degree of MD, the so-called Lambeth MD, and other degrees, by virtue of the power invested in the Archbishop by the Ecclesiastical Licences Act 1533 [16-19]. These Lambeth degrees were named after the principal residence of the Archbishop. This degree has sometimes been misleadingly referred to as "MD Cantuar", a Canterbury degree [18, 20]. However, since the Medical Act of 1858, recipients of a Lambeth MD degree could not practise medicine on the strength of that degree, and since then Lambeth MD degrees have only been conferred on regular medical practitioners whose names appear on the Medical Register [18].

The GMC Medical Register

To practice medicine in the UK, a doctor must have their name on the GMC's Medical Register and, other than F1 doctors, hold a licence to practise [21]. Newly qualified doctors can only enter clinical practice when they receive registration and a licence to practise from the GMC. It is a criminal offence punishable with an unlimited fine to "wilfully and falsely pretend to be or take or use the name or title of physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general practitioner or apothecary, or any name, title, addition or description implying that he is registered under any provision of this Act, or that he is recognised by law as a physician or surgeon or licentiate in medicine and surgery or a practitioner in medicine or an apothecary", or to pretend to have a licence (s49(1) and S49A(1) of the Medical Act 1983) but the more serious offences could include Fraud, Grievous Bodily Harm, Sexual Assault, Misuse of Drugs depending on what "practising medicine" involved.

The essence of the power of the GMC is the maintenance of the Medical Register and its licensing system, which lists the names of all doctors who are regarded by the GMC as being suitable to practise medicine. The GMC controls entry to the Register, deciding what qualifications are necessary for registration, and removing the names of doctors from the Medical Register, temporarily or permanently, when they are deemed to have become unfit to practise (see below). The GMC also seeks to ensure that the public trust in

registered practitioners is justified by ensuring that the educational standard of entry to the Medical Register is maintained, approving and inspecting medical schools and maintaining an oversight of medical education.

GMC guidance on "Good Clinical Practice"

From 1963 to 1993, the GMC published guidance referred to as the "GMC Blue Book", explaining the functions, the procedures and the disciplinary jurisdiction of the GMC. The edition published in 1980 was re-named, adding the words "Fitness to Practise" to the title [22, 23]. Although the reason for introducing this term or its meaning was not set out, this appears to be the first published reference to the term "Fitness to Practise". In 1994, the GMC decided to replace the negatively framed Blue Book, essentially listing the various categories of misconduct and bad practice, by something more positive and inclusive, leading to the publication in 1995 of guidance entitled Good Medical Practice [24, 25], which as the title suggested described the principal attributes of good medical practice. Indeed the guidance starts with a list of the basic duties of all doctors, and the positive approach is maintained throughout with a list of the things that doctors must or should do. This is the core guidance that doctors working in the UK must follow. It shapes the way they care for patients by describing the values and behaviours they must show. The most recent version was published in 2013, and it is intended to publish a revised version in 2023.

The role of the GMC in ensuring doctors are fit to practise

The GMC has had an important influence on the management of problematic medical students and newly qualified doctors. Set out below are details of the two present major strategies, some future plans, and some current as yet unsolved problems.

The meaning of the term "fitness to practise" (FTP)

The UK health and social care all regulators provide differing explanations of this piece of jargon. Some make heavy weather of the topic, and offer lengthy (but differing) explanations. This confusion results, in part, from the fact that the term FTP has been used to describe two different concepts.

One concept embodies a description of the desirable attributes and behaviours that one would wish to find in health and social care professionals and students in training for these professions. The implication is that disregard for these standards could imply impairment of FTP. The other concept can be encapsulated in a single word, namely that FTP is a framework, designed to help manage the cases of individual students or doctors who have exhibited significant behaviour/attitude problems. The main focus of this article concerns this framework as applied to medical students and newly qualified doctors.

The concept of determining a student's FTP may seem somewhat anomalous, given that by definition no student is yet fit to practise their chosen profession.

The term FTP is used by health and social care regulators in some other English-speaking countries such as Ireland, Australia and New Zealand. Elsewhere other terms are used. In the USA, the committee processes for dealing with student behaviour problems can be variously named, for example as a "Promotions Committee" or a "Progress Committee".

Social work as a profession has for many years used the term "gatekeeping" to describe the framework for managing student behaviour problems, and social work literature is well ahead of that concerning medical students. A comprehensive 464 page (18 chapters, 14 appendices) textbook of gatekeeping in social work education was published as far back as 2000 [26] and this includes a full chapter on the history of gatekeeping in social work education starting with the late 1800s.

The GMC and medical student fitness to practise

GMC published guidance for medical students

The GMC was the first UK health regulator to offer guidance on managing student FTP and related matters. It has published comprehensive guidance on:

(i) Achieving Good Medical Practice: Guidance for Medical Students [27]. This sets out guidance for students on the standards expected of them, both inside and outside the medical school. This guidance shows how the principles and values of the GMC's core guidance for doctors, Good Medical Practice [24], applies to students.
(ii) Professional Behaviour and Fitness to Practise: Guidance for Medical Schools and their Students [28]. This provides high-level guidance about managing processes for dealing with concerns about student professionalism and fitness to practise. It recognises that even with the best guidance and support, the behaviour of some students cannot be remedied, so medical schools must have a process in place to identify and deal with students whose conduct or health is such that their FTP may be impaired.
(iii) Supporting Medical Students with Mental Health Conditions [29]. This guidance is designed to help medical schools support students who have mental health conditions. It gives examples of good practice and advice for medical schools how to provide the best possible help to students. This guidance is for medical schools, medical students, and people and organisations involved in postgraduate medical education and training.
(iv) Welcomed and Valued: Supporting Disabled Learners in Medical Education and Training [30]. This guidance refers to statutory requirements for medical schools and organisations involved in postgraduate training, and provides practical suggestions for organisations to consider.

Graduation is impermissible if there are concerns about fitness to practise

A pivotal feature of the UK medical regulatory landscape is that the GMC has repeatedly reminded medical schools and medical students that medical schools must not permit a medical student to graduate as a doctor if there are

concerns about a student's FTP. The GMC's guidance "Achieving good medical practice: guidance for medical students" [27] in its introduction on page 4 warns:

"As a medical graduate, you'll need to register with the GMC and get a licence to practise before you can begin work as a doctor if you wish to work in the UK. The GMC won't register medical graduates who are not fit to practise medicine"

In a later section, at page 44, the guidance warns:

"Medical schools must not graduate any student with a primary medical qualification who they don't consider fit to practise. This means, even if you meet all the competencies to pass your exams, your medical school can only graduate you if it is satisfied you are fit to practise".

The GMC's guidance "Professional behaviour and fitness to practise: guidance for medical schools and their students" [28] under the heading of "Fitness to practise at graduation" on page 14:

"Medical schools must not graduate students where fitness to practise concerns have been raised or are under consideration. Therefore, medical schools must have considered all fitness to practise concerns and reached a determination on them before they allow a student to graduate. By graduating a student with a recognised primary medical qualification, the medical school is declaring them fit to practise as a doctor".

Under the heading of "How fitness to practise affects GMC provisional registration" at pages 14-15, the guidance stipulates:

"Medical graduates who wish to work in the UK must apply to the GMC for provisional registration and answer questions about their health, conduct and any criminal record, which will help the GMC decide if they meet the requirements for registration. The GMC has a statutory duty to register only those doctors whose fitness to practise is not impaired. The GMC must reach this decision and cannot simply accept a decision made by another authority. If there are any concerns, the GMC assess these and will decide whether to grant provisional registration. The law doesn't let the GMC make a conditional grant of registration, or register a doctor and consider their fitness to practise afterwards. At the time of application, a doctor is either fit to practise or not fit to practise. Medical schools should tell students that the GMC is responsible for decisions about registration, and that this includes a separate test of fitness to practise. They should highlight this in admissions procedures, student handbooks and fitness to practise guidance and procedures. Medical schools must make clear to students that the GMC will consider any issue that calls their fitness to practise into question when they come to apply for provisional registration. In exceptional circumstances, this may include incidents that happened before they entered medical school as well as incidents that occur during their undergraduate year".

From medical school to postgraduate education, the GMC sets the standards and expected outcomes for medical education and training in the UK, and it regulates all stages of doctors' professional development, including training for qualified doctors who want to specialise. The GMC is responsible for assuring the quality of education and training and identifying where its standards are not being met. As part of its quality assurance framework, each year the GMC collects data concerning medical student education from each UK medical school, and this includes data on student FTP matters. All UK medical schools are required to have a process for dealing with students with problem behaviours. The details of the process differ between medical schools because each has its own regulations concerning aspects of education provision. To overcome these differences, for the purposes of data collection the GMC has designed a simple system that recognises that 4 different stages can be recognised in student FTP processes:

Stage A: concerns identified and student is monitored and re-evaluated
Stage B: provision of support and pastoral care, health assessment where relevant, and provision of special support and adjustments for disabled students
Stage C: FTP investigation including attending an initial or low-level committee dealing with conduct and health concerns
Stage D: student attends a FTP committee to decide on appropriate additional supervision and support, with the power to apply sanctions including (in the most serious cases) termination of study as a medical student.

The process of applying for provisional GMC registration

Every year, the GMC visits all medical schools in the UK who have graduating cohorts of students [31]. The purpose of these visits is to check final year students' identity details, provide an overview of the registration process, and to emphasise the importance of early disclosure of FTP issues. A key aim is to communicate clear messages to students about the application process, to ensure that they understand that if they have a past or present FTP issue to declare, they should apply well in advance of their foundation year FY1 start date, as soon as the online application process opens. This is because an early declaration gives the GMC time to carry out its investigations and reach its decision before the doctor is due to start work.

In addition to informing students about the GMC provisional registration application process, the GMC also works closely with medical schools to identify students who have had concerns relating to their FTP during their studies. The GMC has an "Early Application Scheme" which involves medical schools sharing information about these concerns with them, which then allows the GMC to invite students with more serious and/or complex FTP issues to apply for registration earlier than the rest of the cohort. As part of this process, in 2020 medical schools told the GMC about 203 students with FTP concerns, and after assessing information relating to the concerns the GMC identified 129 students to be invited to make an early application for provisional registration [31].

When medical graduates apply for provisional GMC registration, they have to complete two declarations, one relating to their health and the other relating to their character

and conduct [31]. Over the years these questions have been refined. When there is a positive health or conduct declaration, the applicant is asked by the GMC to provide additional information.

An application will be referred to the GMC registration investigation team where it meets the threshold for further investigation [31]. This will be decided by the UK team, based on the information in the application, or it will be decided by the registration investigation team from assessing information received by a medical school via the Early Application Scheme.

The threshold for referral for investigation is assessed on a case by case basis. Factors that may trigger referral include events involving violence, threats, sexual impropriety or dishonesty. Patterns of behaviour, medical school disciplinary matters as well as concerns over management of health conditions may also prompt referral for investigation.

On referral to the registration investigation team, the application will be allocated to a caseworker who will collect relevant information and evidence. Once the caseworker has gathered the required information and evidence, they will present a referral bundle to an GMC Assistant Registrar to decide on the application. The Assistant Registrar has several options when making a decision, they may:

- Approve the request for provisional registration
- Request additional information
- Request advice from a GMC Registration Panel before making a final decision;
- Refuse the request for provisional registration

If it is decided to seek advice from a GMC Registration Panel [32], the applicant is informed, and provided with a copy of all the information to be supplied to the Registration Panel. The applicant can submit any written representations or other documents for the GMC to consider. The Registration Panel meets in private, and the GMC aims to provide a copy of the Panel's advice and the decision that has been made within 2 weeks. Registration panels are comprised of medical and lay members. The panel considers the advice requested by the Assistant Registrar, and the panel provides their advice to the Assistant Registrar. The Assistant Registrar then considers this advice when making their final decision.

Graduates who are refused GMC provisional registration

Since 2010, the GMC has refused 51 applications for provisional registration from UK medical graduates [31]. This relates to 46 individuals, some of whom have been refused multiple times.

The figures below (Table 1) show the spread of refused application figures over the last 10 years; on average the GMC refuse applications from five UK graduates per year. The reasons for the very marked year to year fluctuations are not known.

The categories of reasons for GMC refusal to grant provisional registration

There were often multiple reasons why there was a refusal to grant provisional registration [33,34]. The GMC has used the following categories to describe the reasons given by an Assistant Registrar for refusing an applicant:

- Lack of insight - a feature in all 51 refusals.
- Failure to demonstrate remediation – a feature in all 51 refusals
- Probity concern – a feature in 29 (56%) of refusals
- Health issue that posed a risk to patients – a feature in 22 (46%) of refusals

In only four cases was provisional registration refused solely on the grounds of health concerns.

Year	Number of applications refused
2010	4
2011	2
2012	4
2013	2
2014	5
2015	6
2016	7
2017	7
2018	2
2019	10
2020	2

Table 1: GMC Provisional Registration Applications refused by year 2010-2020.

Lack of insight

The term insight encompasses the willingness and ability to (i) recognise and accept that what one has done is wrong, (ii) explore and understand why the adverse behaviours occurred, and (iii) comprehend the reasons why one needs to avoid repeating errors and identify steps that need to be taken to rectify the behaviours. Lack of insight points to a significant risk of repetition of adverse behaviours. The development of insight is not entirely one-sided, and friends and colleagues are often reluctant or unwilling to provide feedback, requiring an active feedback-seeking approach by individuals. Sceptics have argued that the demonstration of insight may in some individuals be a sham [35], the implication being that there is a need to provide evidence that an individual has developed genuine insight and that therefore there is a reduced risk of recurrence of adverse behaviours. Regulatory decision makers in the UK such as the GMC place considerable weight on a practitioner's insight [36].

Lack of insight into failings is a particularly disabling feature that is common to both newly qualified doctors who are refused GMC provisional registration and to fully registered doctors whose names are subsequently erased from the Medical Register which is most commonly the result of misconduct, criminal convictions, or deficient professional performance [35]. The GMC Sanctions Guidance for FTP medical practitioner tribunals [37] advises that "A doctor is likely to lack insight if they:

- refuse to apologise or accept their mistakes;

- promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing;
- do not demonstrate the timely development of insight; or
- fail to tell the truth during the hearing".

In the context of FTP, there is an expectation that doctors will be able to review their own performance or conduct, recognise that they should have behaved differently in the circumstances being considered, and identify and put in place measures that will prevent a recurrence of such circumstances. Lack of insight is a feature common to many student and registrant FTP cases, which is unsurprising given that insight is needed to ensure that the individual doctor has realised that they have indeed gone wrong and therefore will not do anything similar in the future. The main behaviours that point to a lack of insight are:

- failing to take responsibility for one's actions, either blaming others or normalising the behaviour (by saying that everyone does it);
- minimising the seriousness of an adverse behaviour, for example by describing repeated signature forgery or other serious dishonesty as a simple error;
- failing to provide timely expressions of regret and apology, and failing to indicate that the wrongdoer recognises the physical, psychological and social impact of their actions;
- failing to act on advice given at a previous disciplinary or FTP hearing.

Remediation

A major textbook on remediation in medical education explains the meaning of the term remediation by means of a metaphor [38]. "Sailors make many course corrections; they are constantly recalibrating their navigational systems so as to ensure that they arrive where they are going at the expected time. They tack back and forth, rarely heading directly towards their final destination. Medical training (and life) can be like this. The metaphor suggests an aspirational reference point even though you are almost always off course. It also implies a need for exquisite awareness of your current location, your strengths, vulnerabilities and foibles, and an ability to collect and digest wide array of information. Guidance – the sun, the stars, GPS, or a good mentor – is a must, particularly when navigating in unfamiliar waters. All this is essential to safe passage for you and those for whom you are responsible".

In short remediation means taking steps to addresses concerns about knowledge, skills, conduct or behaviour [39-42]. Important components of remediation include demonstrating regret or remorse, and apologising. Apologies are often badly constructed, and recent advice has been published concerning the optimum design and use of apologies [43].

Insufficient time available to demonstrate remediation

The GMC in its advice "Professional behaviour and fitness to practise: guidance for medical schools and their students" [28] draws attention to the problem of when concerns are raised about a student in the final year of study, with insufficient time to resolve them. The guidance (page 34) states:

"If a concern about a student's fitness to practise is raised close to the date of graduation, then the medical school should consider the amount of time the student will have to demonstrate remediation. It may be necessary to require a student to repeat all or part of a year, if appropriate. But in cases where there is an outstanding, justifiable concern over a student's fitness to practise, the medical school must not graduate the student".

The need to be able to demonstrate an ability to manage without intensive support

A related problem is the student who is only able to overcome persistent problems with professional behaviour provided very extensive support is provided. An example is a student who persistently failed to attend teaching sessions or appointments to discuss professional matters despite repeated warnings unless a reminder was provided by support staff shortly before every single event. The student was effectively receiving what one might call "educational intensive care". Past experience has shown that the GMC will not grant provisional registration unless a student has been able to demonstrate an ability to function professionally without continual reminders. As with patients receiving artificial ventilation on an intensive care unit, before being allowed to leave intensive care the patient needs to be able to demonstrate the ability to breathe without the support of a ventilator.

What happens after provisional GMC registration has been 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 to the Registration Appeal Panel. 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 in its registration decision letter have been addressed and overcome. In the years 2010-2020, there were 51 refusals involving 46 applicants [31].

Of these 46 applicants that have been refused provisional registration, 28 applicants (61%) went on to successfully obtain provisional registration, having successfully demonstrated that they had remediated.

Of the remaining 18 applicants who were refused registration and who had not gone on to obtain provisional registration, 11 chose never to reapply. Four applicants made subsequent applications, but these were closed or withdrawn before a decision was provided.

Three of the refused applicants have been refused registration on multiple occasions. Two applicants have been refused twice and the other applicant has been refused on four occasions.

What happens when waiting for a decision about provisional registration

Individuals cannot take up an FY1 post and enter clinical practice until the GMC grants provisional registration.

Discussion

We have set out information about two important strategies intended to ensure only graduates who are suitable for practice are permitted to start seeing and treating patients in the first year of postgraduate training. The first strategy requires medical schools to address behaviour problems occurring in medical students, using the FTP process which is in place in every UK medical school, one driver for this being the GMC's insistence that students where there are concerns about FTP are not permitted to graduate and obliged to remediate or leave the programme. The second strategy is that before being allowed to commence working as a doctor, newly qualified doctors must first obtain provisional registration with the GMC, and during this process a small number of newly qualified are refused registration and cannot start work as a doctor. Some unresolved issues remain, and these are discussed below.

The student who leaves before completion of FTP processes

The literature on medical school dropout is relatively scarce. Helpful reviews come from O'Neill [44, 45] and Reibnegger & Manhal [46]. An unresolved problem concerns a student who has been referred to a FTP committee but who leaves the programme before a FTP committee meeting can be held. The main reasons for this not uncommon occurrence are:

Academic failure: a student repeatedly fails one or more summative examinations, the regulations requiring that the student's studies are terminated. A high proportion of medical students referred to the University of Manchester FTP committee have demonstrated significant academic problems, having had to resit examinations (and sometimes having had to repeat a whole year of study).

Serious criminal convictions: a student realises that there is little prospect of being permitted to remain on the programme by an FTP committee because of the gravity of a criminal conviction. Examples include a student convicted and imprisoned because of a violent assault involving firearms, a student convicted and imprisoned because of a sexual assault, a student convicted and imprisoned because of fraud, or a student convicted and imprisoned because of the crime of perverting the course of justice.

Change of career intention: despite the best efforts of those involved in decisions about admission to the programme, one still encounters a few students who have little or no wish to study medicine. Sometimes a student comes to realise that medicine is not the career they wish to pursue. On a few occasions students have been heavily pressurised by their family, against their wishes, to study medicine. After all manner of difficulties which can eventually lead to referral to an FTP committee, a student may decide to leave the programme.

The GMC has expressed concern about students who leave voluntarily before the completion of FTP procedures, and in its guidance "Professional behaviour and fitness to practise: guidance for medical schools and their students" [28] (see page 63) it states:

"Medical schools and universities should review their fitness to practise procedures to include appropriate measures to address a situation where a student with a fitness to practise concern leaves voluntarily before a conclusion is reached. All cases that reach a hearing should come to a formal decision and conclusion, even if the student leaves voluntarily before a hearing has concluded. Medical schools must give a student a full opportunity to participate in the hearing, even if they leave voluntarily".

However, many UK medical schools are unable to comply with this guidance, because it is clear that their FTP regulations and procedures only apply to current medical students. The university therefore has no power to apply its rules and regulations after a student has exited from the programme and left the university. A workaround used by a few medical schools has been to re-write their FTP regulations to make it clear that once FTP procedures have been commenced they must be completed, even if the student has left the programme.

Career recycling [47]

This term refers to the fact that some health care students who have been excluded from a programme then proceed to apply to study for a qualification in the same programme or another health care programme, usually at a different university. Their university application form almost always fails to mention the previous failure. There have been attempts to set up databases of excluded students, to enable universities to check the names of all applicants against the names in a database of excluded students. These databases are far from straightforward to operate, and there is no published data to indicate their effectiveness. One potential problem is that excluded students sometimes change their name and data of birth on an application form, to prevent detection by an excluded student database. Applicants sometimes change their name and their date of birth, knowing that a criminal record check would disclose a serious crime which would prevent admission to a healthcare programme. There are a number of universities in Europe that offer various healthcare programmes entirely provided in English, and a number of students excluded in the UK have successfully studied a programme in the same discipline in a European country.

Assessing FTP during the selection and admission process

The selection and admission process, including an interview of the applicant, in theory provides an opportunity to detect individuals who are unsuitable for a career in medicine. Self-evidently it would be an advantage if one could detect, prior to admission, individuals who will go on to have their career halted because their FTP has been found to be impaired. The whole process of selection of applicants who wish to study medicine is complex and controversial subject [48]. All we know for certain is that the selection processes currently and previously in place at present fails to detect and

reject the small number of individuals who later turn out to be totally unsuitable for a medical career.

There are two other methods that offer the potential to avoid admitting unsuitable applicants to a health care education programme. One is that all applicants in the UK have to undergo a criminal record check in which their name and date of birth are checked against a database of those with a criminal record. Universities have different processes for dealing with disclosures of previous criminal records, either freely provided by the applicant or discovered by a criminal record check, and making decisions about suitability for the intended career. The process is likely to involve the applicant being given an opportunity to report and explain their past actions, often events when the applicant was only a child. Decisions have to take into account, including the age of the child when the offence was committed, the Rehabilitation of Offenders legislation, and the views of education partners such as hospital placement providers.

The second method is that applicants are required to complete a health questionnaire, the results of which will be assessed by the university occupational health service, and applicants with significant health problems and disabilities that might affect their ability to work as a health professional are likely to need to be seen and assessed in person by an occupational health specialist. Particular difficulties can arise in the case of disabled applicants, because they cannot be compelled to disclose a disability, which may later come to light when it becomes clear that a disability exists. The GMC has provided helpful guidance on how education providers can support students with significant health problems and disabilities [29,30].

Problems arise when an offer of a place on a programme is followed by commencement of studies after only a very short period, which can happen in the UK when applications to university are dealt with at a very late stage, providing no opportunity for a university to go through the processes for checking criminal records and assessing applicants with significant health problems and disabilities before an individual joins a health care programme.

The possible use of situational judgment testing when selecting applicants

A situational judgement test (SJT) is an assessment format in which the test-taker is presented with a series of scenarios depicting an interpersonal situation. The test is to evaluate several possible behavioural responses to each scenario. The responses are ranked either in order of appropriateness or effectiveness, and the test [49-51] and the SJT has been used as a tool to aid the selection of applicants to medical school and the selection of new graduates applying to the Foundation Programme [52-57]. Most SJT's have highlighted core broad desirable attributes of newly qualified doctors such as commitment to professionalism, coping with pressure, effective communication, organisation and planning, patient focus, working effectively as part of a team. However from work on identifying important personal attributes, the construct of integrity has emerged as a front-runner [58], and there has been particular interest in integrity-based SJT's, following studies in the UK [58] and the Netherlands [53]. However, whether an integrity-based SJT can be designed to predict adverse behaviours resulting from a lack of integrity remains to be seen.

UK National licensing examination – the GMC Medical Licensing Assessment

A number of studies have demonstrated marked variation in the way that different UK medical schools assess the performance of medical students [59-62], leading to a concern that there is a lack of evidence that UK medical students achieve a common standard on graduation [63]. In the past there was, in addition, concern about the standard of students who qualified by passing the examination of a non-university body such as the conjoint diploma awarded by the Royal Colleges of Surgeons and Physicians in London, Edinburgh and Glasgow, or the LMSSA (Licentiate in Medicine and Surgery of the Society of Apothecaries) [12, 13].

As a result, the GMC is to introduce a Medical Licensing Assessment (MLA) to be taken by every UK medical student [64]. 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 MLA will test the core knowledge, skills and behaviours needed to practise safely in the UK. The assessment will be led and delivered by UK medical schools, and regulated by the GMC. The MLA will make it possible, for the first time, to demonstrate that graduates from each UK medical school have met an agreed standard of proficiency and are well prepared to practise medicine as Foundation Year doctors. The MLA will also provide assurance that anyone who obtains a UK medical degree will have shown that they can meet a common and consistent threshold for safe practice before they are licensed to work in the UK. Although the MLA will be a common part of a medical degree, the GMC is not aiming to make all undergraduate medical courses look the same. Medical schools will still be able to teach across a range of areas and assess across a broad curriculum. The MLA will be a pass/fail assessment. It is not designed to rank medical graduates, and scores will not be used in the Foundation Training selection process.

What the assessment will involve

The MLA will be a two-part assessment made up of an applied knowledge test (AKT) and a clinical and professional skills assessment (CPSA) which will be embedded within UK medical schools' finals exams from the academic year 2024-25 [65-67].

The applied knowledge test (AKT)

This is planned to be an on-screen exam, run by medical schools, with multiple choice questions. It will test ability to apply medical knowledge to different scenarios.

The clinical and professional skills assessment (CPSA)

This will be an assessment of clinical skills and professional skills, which each medical school will set and run. Each medical school may call the CPSA something

different - for example, an Objective Structured Clinical Examination (OSCE) or Objective Structured Long Examination Record (OSLER). The GMC will set requirements that all CPSAs must meet.

Conclusions

Having a single national regulator for doctors, the GMC, confers many benefits. This article sets out how the direct and indirect influence of the GMC helps to ensure that newly qualified doctors in the UK are ready to enter clinical practice. The principal tools are extensive guidance, for students and for education providers, concerning both expected behaviours and what to expect when there are significant concerns about the behaviour of a medical student or newly qualified doctor, coupled with mechanisms to ensure the FTP of students and newly qualified doctors. The process for assessing the FTP of students involves their attendance in person at a university decision-making committee, whereas the assessment of the FTP of newly qualified doctors is largely a paper-based exercise run by experienced GMC staff, and the two approaches complement one another.

Disclosures

Contributors

TJD produced the first draft of the paper and SE and TJD then contributed to iterative drafting and refinement of the manuscript.

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