

15 November 2007

Steve George  
Clerk to the Committee,  
Assembly Parliamentary Service,  
Cardiff Bay,  
CF99 1NA

Dear Clerk

**GMC Workforce Planning Submission**

Many thanks for the opportunity to submit our written evidence to the workforce planning inquiry. Should you have any questions or comment, please do not hesitate to get in touch.

Yours sincerely

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**National Assembly for Wales Health, Wellbeing and Local Government  
Committee inquiry into Health and Social Care Workforce Planning**

**Evidence from the General Medical Council**

1. The GMC welcomes the opportunity to assist the Health, Wellbeing and Local Government Committee in its Inquiry into Health and Social Care Workforce Planning.

2. As national regulator of the medical profession, the GMC makes an important contribution to the healthcare systems in all four countries of the UK. We are pleased to have the opportunity to describe our roles in relation to registration and to medical education and training.

*Statutory purpose*

3. Under the Medical Act 1983, the GMC's purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

4. In support of this purpose, the GMC has four interlocking and complementary functions:

- a. Controlling entry to the medical register.
- b. Setting the educational standards for medical schools.
- c. Determining the principles and values that underpin good medical practice.
- d. Taking firm but fair action against doctors when those standards have not been met.

*The GMC and Wales*

5. The GMC is committed to ensuring that regulation is sensitive to the context of health provision in Wales. To ensure we engage effectively with key interest groups, including the Welsh Assembly Government, patients and the public, the medical profession and the NHS in Wales, the GMC established an office in Cardiff in 2005. This presence in Wales has allowed the GMC a greater understanding of developments in health regulatory and delivery structures in Wales, and to incorporate this experience into our guidance and policy.

6. In May 2005, the principal external review bodies inspecting, regulating and auditing health and social care in Wales agreed a set of objectives and practices (a Concordat) to support the improvement of services for patients, service users and carers and to eliminate any unnecessary burdens of external review. In September

2006, the GMC became the 11th full signatory to the Concordat. This will enable the GMC to continue to strengthen the GMC's links with other regulatory and inspecting bodies in Wales.

7. As part of our ongoing programme of reform, we plan to be ready to introduce the first stage of revalidation – the introduction of the licence to practise – at the end of 2008. Periodic review of a doctor's fitness to practise will commence thereafter. To assist with revalidation the Wales Deanery in collaboration with the GMC and the Welsh Assembly Government is running a project in general practice in the NHS in Wales. The project aims to:

- Assess the extent to which Local Health Boards (LHBs) in Wales constitute approved working environments as currently described by the GMC
- Establish whether, in practice, the GMC can rely on the outputs of these appraisal and clinical governance systems (which are the responsibility of the NHS in Wales) to contribute to the revalidation of doctors.
- Develop a framework for approving working environments.

#### *Registration*

8. Doctors must be registered with the General Medical Council to practise medicine in the UK. There are three main routes to registration:

- a. For doctors who qualified at a UK medical school.
- b. For doctors who qualified within the European Economic Area and are EEA citizens or have European Community rights.
- c. For international medical graduates who qualified outside the EEA or who qualified within the EEA and do not benefit from European Community rights.

9. Table 1 shows the total number of new registrations each year from 2002 to 2006, subdivided across the three main routes. Please note that this information is not necessarily indicative of the number of doctors entering the workforce in the UK. For historical reasons many doctors have held GMC registration, though they remain resident in another jurisdiction. For example, in 2003 the closure of a former direct route to registration (without an assessment of medical knowledge and skills) for doctors qualifying from seven countries ceased. Several thousand IMGs secured registration prior to the closure of the route, though there is no evidence that they planned to come to the UK in the foreseeable future.

**Table 1**

Year	UK doctors	EEA doctors	IMGs	Total new registrations
2006	48%	29%	23%	11,877
2005	32%	16%	52%	14,835
2004	32%	24%	44%	14,737
2003	25%	10%	65%	18,684
2002	39%	14%	47%	11,235

*EEA doctors*

10. The surge in EEA registrations in 2004 was the result of the expansion of the EEA through the addition of the EU accession countries. In 2007 we have experienced considerable interest in registration from Bulgarian and Romanian doctors following their country's accession to the EU in 2007. By October 2007 the following number of applications were received:

- a. Bulgaria – 150
- b. Romania – 277

11. The numbers of newly registered EEA doctors may not provide a reliable indicator of the doctors who joined the UK workforce for the first time. Although all EEA doctors must now complete the registration process in the UK, we are aware that a proportion of EEA doctors secure registration in advance of deciding to practise here.

*International medical graduates (IMGs)*

12. Table 1 shows that the percentage of IMGs gaining new registrations (23%) has dropped sharply from the numbers seen in previous years. 44% in 2004 and 65% in 2003.

13. The surge in IMG registrations in 2003 was stimulated by the impending withdrawal of the special recognition, for historical reasons, of qualifications from seven countries – Australia, Hong Kong, New Zealand, Singapore, South Africa, the West Indies, Singapore and Malaysia. Qualifications from those countries are now treated on the same basis as other countries outside the EEA.

14. From 2004 onward, the numbers of newly registered IMGs provide a reasonably reliable indicator of the doctors who joined the UK workforce for the first time. IMGs must complete the registration process in the UK and registration, prior to 19 October 2007, was granted only when the applicant had secured an offer of

employment. This was less true prior to 2004, for example, because of the special recognition explained above.

15. From 19 October 2007 the requirement to have secured an offer of employment prior to a grant of registration was removed as part of a new registration framework (part of a Section 60 order we requested amending the Medical Act 1983). Most IMGs secure registration having demonstrated their knowledge and skills by passing the Professional and Linguistic Assessments Board (PLAB) test. The PLAB test is in two parts, with Part 2 being available only in the UK. Doctors must pass Part 1 before taking Part 2. The great majority of IMGs who secure registration are seeking employment in training grades, not as specialists.

16. The number of PLAB test applicants rose steadily from 2000, when about 3,400 doctors took Part 1, to a peak in 2004, when about 12,600 doctors took Part 1. The numbers taking Part 2 rose correspondingly, from about 1,349 in 2000 to about 8,200 in 2004.

17. There has been widespread concern that the numbers of IMGs who have passed Part 2, and are in the UK seeking work, greatly exceed the number of posts available. Among other things, this has led to calls that the GMC should ration test places, particularly for Part 2, on the basis that this would help to secure a better match between the demand for, and supply of, jobs. This, however, would be unlawful.

18. We have, however, sought to work with the Department of Health and others to improve the information available to IMGs who are considering coming to the UK and to ensure that they understand that passing the PLAB test does not guarantee employment. For example:

a. In 2004 we began a regular survey of IMGs who had passed the PLAB test, to collect information about their employment experience in the UK. The results are published on our website. We would be pleased to supply a copy of the most recent survey results if that would be helpful.

b. We recruited, as advisers, a group of doctors who had taken the test, to assist in rewriting the information we provide. It includes fuller information on job prospects, finding work, and on life in the UK. Doctors must confirm that they have read the relevant sections of the guidance before booking a Part 1 test place.

a. We work with others to try to provide a picture of the UK job market. However, there is undoubtedly room for further improvement.

b. In 2005, in conjunction with the Department of Health and the BMA, we commissioned a survey that looked at the employment experience of recently qualified UK doctors. We would be pleased to supply a copy of the survey

results if that would assist the Committee. It can also be viewed on our website at [www.gmc-uk.org/doctors/employment\\_surveys/index.asp](http://www.gmc-uk.org/doctors/employment_surveys/index.asp).

c. In late 2006 we produced a guidance leaflet for IMGs that provided a realistic overview of the process they would have to follow to gain employment as junior doctors in the UK. The guidance included information on job prospects and the cost of living in the UK.

19. The steps we and others have taken to improve the availability of information, combined with feedback through IMG networks, have led to a sharp drop in applications for Part 1 of the PLAB test. This downward trend has continued with 3,979 Part 1 tests taken in 2006 and to date only 1,955 Part 1 tests taken in 2007.

20. While further analysis would be required, the experience of recent years appears to demonstrate that the supply of IMGs who wish to work and train in the UK can be stimulated and depressed through the availability of good quality information about the market.

21. On 7 March 2006, the Home Office announced that all IMGs wishing to work in the UK would be required to have a work permit from July 2006. We continue to communicate this change to potential candidates via our website and, as the figures for 2006 and 2007 show, a further drop in the numbers of applicants has occurred.

#### *Medical education and training*

22. Under the 1983 Act, our Education Committee has the general function of promoting high standards of medical education and co-ordinating all stages of medical education. The 1983 Act lays down specific roles for the Education Committee in relation to undergraduate education and training for doctors with provisional registration. Doctors are granted provisional registration, usually for one year, on completion of their medical degree to enable them to continue their training in a managed environment.

23. The Postgraduate Medical Education and Training Board has functions relating to postgraduate medical education and training, set out in the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. Effective medical education and training requires doctors with the time and the skills to deliver it in the workplace.

24. The GMC has welcomed the recommendation of Sir John Tooke's inquiry into Modernising Medical Careers for the assimilation of PMETB into the GMC. This will provide a continuum of regulation of undergraduate and medical education and training, continuing professional development, quality assurance and enhancement. This supports the proposals outlined in our previous paper, The GMC's Proposals on Healthcare Professional Regulation, in November 2006, where we supported the case for better co-ordination of medical education and training by bringing all stages

– undergraduate, postgraduate and continuing professional development – under one roof.

25. Neither the GMC nor PMETB has a remit to set the number of medical students and trainees. In Wales, decisions about medical student numbers are made between the Higher Education Funding Council for Wales and the Welsh Assembly Government's Health Directorate.

26. In relation to undergraduate medical education, the GMC Education Committee determines the 'knowledge and skills' and the 'standard of proficiency' required on graduation from a UK medical school and we also set standards for medical schools. The guidance is set out in Tomorrow's Doctors which is available on the GMC website at [www.gmc-uk.org](http://www.gmc-uk.org). We would be pleased to supply a copy if that would assist the Committee.

27. The GMC Education Committee ensures that undergraduate medical education is appropriate but does not attempt to define the workforce or other resources needed. In Tomorrow's Doctors we state that medical schools must ensure that their staff follow our guidance and are provided with the necessary training (paragraph 97). The UK health departments must make facilities available for students to receive training and decide how students may have access to patients (paragraphs 99 to 100). 'Doctors with particular responsibility for teaching students must develop the skills, attitudes and practices of a competent teacher. They must also make sure that students are properly supervised,' (paragraph 103).

28. To develop appropriate knowledge, skills, attitudes and behaviour, medical students should have contact with patients throughout their undergraduate courses. Tomorrow's Doctors states, 'From the start, students must have opportunities to interact with people from a range of social, cultural and ethnic backgrounds...Such contact with patients encourages students to gain confidence in communicating with a wide range of people, and can help develop their ability to take patients' histories and examine patients,' (paragraph 50).

29. Medical schools, therefore, place students in a variety of NHS settings. It is important that workforce planning adequately takes into account the need for doctors to find the time appropriately to train and assess medical students, without detriment to NHS services. Training inevitably reduces the number of procedures that can be carried out in the NHS, as doctors must take the time to show students what to do. It is essential that workforce planning takes into account this relationship between training and throughput.

30. In addition, doctors and other health service staff are involved in teaching medical students on university premises and in associated research. Workforce planning therefore needs to reflect the requirements of medical schools with their expanding student roles.

31. Following medical school, graduates now enter the two-year Foundation