GMC Consultation on a review of the Future Regulation of Medical Education and Training

1. I write with regard to the GMC consultation on a review of the future regulation of medical education and training (the Patel Review).

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the ‘voice’ of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 38,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

3. The College welcomes the opportunity to comment on this document. We feel it is a very positive and well written review, and features many sensible recommendations which the College would support. It offers a clear way forward, which will allow a measured approach to be taken in achieving benefits from the merger of the GMC and PMETB, to the advantage of the medical profession and patients alike.

4. We would like to make some specific points about the individual Review Recommendations, which we have listed here:

   **Review recommendation 1:** We agree on the emphasis on protecting the public. We would question, however, the point made in paragraph 43, that the sanction of withdrawing training recognition should be a ‘last resort.’ This sanction has to be real in order to support management priority of training...
alongside service delivery – poorly supervised training by definition is a risk to patient safety.

**Review recommendation 3:** We agree – education and training providers need to be much more involved, and senior managers be made aware of their responsibility to ensure that there is adequate support for training, so that it does not play ‘second fiddle’ to service delivery in their priorities. We would add that closer attention should also be paid to the relationship with the commissioners of education and training, as this is where the onus of most assessment and regulation will necessarily lie.

**Review recommendation 4:** We strongly agree with this. An overview of all stages of training is important. Trainees and young doctors are generally at their most vulnerable at times of transition, and additional guidance on managing transitions is welcome. Furthermore, effective mechanisms for providing continuity of information between stages would be very welcome, such as a formal portfolio carrying development information throughout education and training. A national working group would be a useful mechanism to effect these changes.

**Review recommendation 5:** We agree, and also feel that it would be highly useful to work towards national and international standards for ‘interoperability’ of data sets – that is, to facilitate information sharing across boundaries.

**Review recommendation 6:** We strongly agree that the GMC should not be involved in selection into medical school – it does however have a role in setting minimum standards (for example in relation to prior professional risks such as criminal convictions) and offering advice on selection, particularly in helping to ensure diversity in the undergraduate population.

**Review recommendation 7:** We agree, and the outputs of this evaluation should be open to external scrutiny.

**Review recommendation 8:** We strongly agree. The GMC should look more closely than hitherto at the impact of its recommendations. Some of our members do express concerns over the consistency of outputs from undergraduate medical education.

**Review recommendation 10:** We agree strongly (as per Recommendation 8)
**Review recommendation 11:** We agree. It is also important to consider effective ways of assessing outcomes, such as the continuous process of Workplace Based Assessment.

**Review recommendation 12:** We agree. It is important to establish standards for accreditation of trainers, particularly in secondary care. The RCGP has much experience in this area, and would be keen to work with the rest of the profession in developing these. Some of our members would argue that the GMC’s involvement should be in monitoring and accrediting the process by which trainers are assessed, rather than managing the accreditation themselves. Also, it is important that the accreditation process not be made so complicated and burdensome as to deter those who wish to be trainers.

**Review recommendation 13:** We strongly agree that it would be beneficial to consider closer regulation and accreditation of training environments. This could be done through establishing a *model* of an educational environment that supports development, the enforcement of which might be left to deaneries. The failure to produce a properly robust mechanism for approving posts, programmes and environments has been one of the disappointing aspects of the PMETB in the past, resulting in some trainees not undergoing a broad and balanced programme.

**Review recommendation 14:** We agree, though again the GMC should consider the need to work through deaneries on this.

**Review recommendation 15:** We agree strongly, as we feel the processes are not at present working as intended. In particular, in the case of CEGPR, there has been an inappropriate exclusion of medical professional comment. There also needs to be close consideration of issues relating to the recognition of specialist qualifications from other EEA member states.

**Review recommendation 18:** We agree with the uncoupling of register entry and certification – with the condition that this not create an additional barrier for individual doctors embarking on their careers.

**Review recommendation 19:** We agree that this area requires close review, particular in the light of recent high profile cases. The GMC should also take cognisance of any doctors who have been struck off abroad but allowed to practice in the UK.
Review recommendation 20: The GMC must be careful to maintain a balance in its regulatory role on CPD. It is important to consider all environments, technologies and mechanisms of CPD, and there should be further research into their relative effects. But this should not be at the expense of diversity in CPD, or any attempt to move to a one-size-fits-all model, as doctors clearly find different ways of keeping up-to-date effective. Any CPD guidance should also be in line with Academy CPD principles, so as not to undermine Colleges’ work on revalidation.

Review recommendation 21: We agree, though the parameters of this greater flexibility should be carefully defined.

Review recommendation 23: We agree. There needs to be much more emphasis on outcomes rather than process.

Review recommendation 25: We fully agree, and feel this is a very important point.

Review recommendation 27: We entirely agree with the principle that ‘the beneficiary pays’. The funding arrangements for quality assurance of medical education and training need to be robustly debated. The bottom line is that patients are the ultimate beneficiaries of good quality medical education, and the cost to the government of poor clinical care will far outweigh the cost of any quality assurance system of medical education.

5. We gratefully acknowledge the contributions of Dr Mark Purvis, Dr Bridget Osborne, Dr Ruth Palmer, Dr Bill Reith, Dr Jenny Stephenson, Dr Kate Diacon, Professor Sean Hilton, Dr Steve Watkins, Dr John Howard, Dr Jill Edwards, Dr Barry Lewis, Dr John Leigh and Ms Jaspreet Grewal. While contributing to this response, it cannot be assumed that those named all necessarily agree with all of the above comments.

Yours sincerely

Professor Amanda Howe
Honorary Secretary of Council