Review of the Routes to the GP and Specialist Register: Final Report

General Medical Council

Regulating doctors
Ensuring good medical practice

January 2012

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Executive summary

1.1 In his 2010 report *Recommendations and Options for the Future Regulation of Education and Training* Lord Patel proposed that the GMC review the arrangements through which doctors who have not completed general practice (GP) or specialist training in the UK can be granted GP or specialist registration if they have demonstrated equivalent knowledge, skill and experience in other ways. Lord Patel said that the aim of the review should be to ensure that the processes for establishing equivalence:

'are fair, efficient and fit for purpose, and… continue to ensure standards are maintained.'[1]

He particularly noted concerns about the current arrangements for assessing the equivalence of applicants. This working group was set up to lead the review on behalf of the GMC.

1.2 At the heart of this recommendation is the need for the GMC to make sure that the interests of patients and the public are protected and that they, as well as employers and the profession, can have confidence in the standards of doctors admitted to the GP and specialist registers. This has been the guiding principle of our review.

1.3 The current processes for assessing equivalence date from 2005 and the establishment of the Postgraduate Medical Education and Training Board (PMETB). Between 2005 and 2010 1,528 doctors in hospital specialties and 1,326 doctors in general practice have been awarded certificates of equivalence. While the equivalence processes have undoubtedly improved the opportunities for doctors to obtain GP or specialist registration, they have been slow, bureaucratic and resource intensive. They have relied heavily on the accumulation of documentary evidence of past experience, knowledge and skills rather than on robust peer evaluation of contemporary performance. It is a system that is not well understood by the profession or employers and one that is distrusted by many of the doctors who use it. A new approach is needed.

1.4 Doctors with GP and specialist registration have greater practising autonomy than other licensed doctors. The means of assessing eligibility for GP and specialist registration should reflect this. We therefore consider that any doctor wishing to demonstrate their equivalence for registration purposes must have practised in the UK relatively recently in order to become familiar with the context of medical practice within the UK health services. This is not currently the case.

1.5 The current reliance on applicants providing documentary evidence of past knowledge, skills and experience should be replaced by emphasis on formal evaluation of performance in practice in the relevant specialty in the UK. The evaluation should draw on the assessment tools developed by the medical royal colleges for the relevant CCT specialty curriculum and include a series of mandatory assessments of performance. Assessments should be carried out by educational supervisors who are recognised as trainers. The process should be overseen by the postgraduate deaneries.

1.6 The introduction of evaluations of performance will reduce the current dependence on documentary evidence to demonstrate that applicants have achieved the required standards. In future, the documentary evidence required from applicants should concentrate on those areas not already assessed through the evaluation of performance and knowledge.

1.7 The question of how the GMC should satisfy itself about applicants' specialist knowledge, as distinct from performance, has been a challenging one for the review. Applicants must possess sufficient breadth and depth of knowledge in their specialty to support the required standards of performance. There are different views on how this should be demonstrated and, in particular, whether it is proportionate or feasible to require a formal knowledge test. Our report explores some of the options, but we recommend that the GMC should consult more widely on the appropriate way forward.

1.8 Each year the GMC receives a small number of applications for specialist registration from figures of high international standing who are recognised as eminent in their field and who wish to take up senior clinical or academic posts in the UK. UK healthcare and UK patients benefit from their expertise and the regulatory requirements should not act as a deterrent to them coming to the UK. In exceptional cases of this kind, special arrangements should apply. Since it would not be practical for such individuals to undergo a period of evaluation of their performance in UK medical practice they should be assessed on the basis of robust documentary evidence of their credentials.

1.9 The current process for evaluating equivalence applications relies on the medical royal colleges assessing documentation provided by individual applicants and making recommendations to the GMC about whether the application should be approved. Our report includes a number of proposals for improving this process, including better engagement between the GMC and college evaluators, better use by the GMC of specialist expertise, more streamlined decision making processes within the GMC and greater accessibility of information and transparency about how decisions are made.

1.10 Transparency and accessibility of information are important because many key stakeholders lack understanding of the equivalence processes. That lack of understanding disadvantages doctors who have demonstrated their equivalence when compared with their colleagues who have completed GMC approved training programmes. The GMC therefore needs to undertake a comprehensive communications programme to promote the visibility and understanding of the enhanced processes recommended in this report.

Context and recommodations

Section 1: Background

Understanding GMC registration and the licence to practise

1 To practise medicine in the UK a doctor must be registered and licensed with the GMC.

2 Newly qualified doctors are granted provisional registration. This enables them to undertake the first stage of their postgraduate training.

3 Once they have met the standards and specified outcomes of the first year of their postgraduate training under provisional registration they are granted full registration. With full registration most doctors will proceed through specialty (including general practice) training, although some may enter other employment as a doctor in the UK or overseas.

4 Doctors who have completed specialty or general practice training can apply to be included in the GMC's general practitioner (GP) register or specialist register.

Understanding CESRs, CEGPRs and CCTs as routes to GP and specialist registration

5 To be eligible for appointment as a substantive, honorary or fixed term consultant in one of the UK health services, or to work as a general practitioner (GP) in the UK, doctors must be on either the specialist register or the GP register.[2]

6 To this end most doctors go through an approved GP or specialty training programme. The curricula and assessment systems for these programmes are developed by the medical royal colleges and faculties and approved by the GMC. Once a doctor has completed an approved programme they are awarded a Certificate of Completion of Training (CCT) and this confers eligibility for inclusion in the specialist register or GP register.

7 However, not all doctors go through this process. For example, some international medical graduates (IMGs) may not have completed specialist training in the UK. Some UK trained doctors may have chosen not to undertake an approved specialist or GP programme or have completed only part of a programme. They may, nevertheless, be highly competent and experienced doctors in the field in which they are working.

8 Routes have therefore been developed to enable doctors who have not completed GMC approved specialist or GP training programmes to demonstrate that they have the knowledge, skills and experience equivalent to that required for a CCT or for practice as a consultant in the NHS. These are referred to as the 'equivalence routes' to GP and specialist registration. Doctors who demonstrate equivalence receive from the GMC a Certificate of Eligibility for Specialist Registration (CESR) or a Certificate of Eligibility for GP Registration (CEGPR).

9 Doctors who have been appointed onto an approved specialty training programme after undertaking part of their training in unapproved posts and subsequently go on to complete the programme are eligible for a CESR or CEGPR Combined Programme (CESR/CEGPR(CP)).

10 CESRs, CEGPRs, CESR(CP)s and CEGPR(CP)s all confer the same eligibility for specialist and GP registration as the CCT equivalent.

11 It should also be noted at this point that separate arrangements govern the recognition of training and qualifications of doctors from the EEA. These are dictated by EC law and have been outside the scope of this review.

Some history: from PMETB to GMC

12 The current arrangements for evaluating CESR and CEGPR applications date from the establishment of the Postgraduate Medical Education and Training Board (PMETB) in 2005.[3]

13 In April 2010 PMETB was abolished and its functions transferred to the GMC. In order to ensure a smooth transition as little as possible of the existing process was changed at the time of the merger. The substance of the legislation under which PMETB had operated (including that relating to the equivalence processes) was left intact, as were the policy and operational processes. The legislation and policies remain in place today with some streamlining of operational processes. It is these inherited systems that have been the subject of our review.

Understanding the current process

14 The legislation[4] provides that doctors are eligible for a CESR or CEGPR if they have:

- undertaken specialist training or obtained specialist qualifications in a UK recognised[5] specialty which is determined by the GMC to be equivalent to a CCT in that specialty; or
- undertaken specialist training or obtained specialist qualifications outside the UK in a specialty not recognised in the UK which satisfy the Registrar of the GMC that they give a level of knowledge and skill consistent with practice as a consultant in any of the UK health services; or
- knowledge of, or experience in, any medical specialty derived from academic or research work which satisfies the Registrar of the GMC that they give a level of knowledge and skill consistent with practice as a consultant in any of the UK health services.

15 Applicants for equivalence in a CCT specialty must therefore demonstrate that their knowledge, training and experience, when mapped against the relevant CCT curriculum, are equivalent to the standard required for their specialty. Applicants in specialties which have not been recognised for CCT purposes (often referred to as 'non-CCT' specialties) must demonstrate equivalence to the standard for a 'day-one' consultant.

16 All applications are considered under four domains:

Domain 1: Knowledge, skills and performance

Domain 2: Safety and quality

Domain 3: Communication, partnership and teamwork

Domain 4: Maintaining trust.

17 These domains mirror the four domains contained in the GMC's *Good Medical Practice Framework for Appraisal and Assessment* that has been developed for revalidation. The adoption of this four domain model followed PMETB's own review of the CESR/CEGPR process in 2008.

18 Applicants provide a portfolio of documentary evidence relating to their training, qualifications and experience. It is for them to decide what they wish to submit to the GMC. However, the majority of their evidence (95%) is recommended to come from domains 1 and 2. Applicants are encouraged to take account of specialty specific guidance developed by the medical royal colleges and the GMC which describes the sort of evidence they are advised to submit relevant to their particular specialty. This is based on the GMC approved curricula and assessment systems for the specialty.

19 Once an application is received by the GMC it is sent to the relevant medical royal college or Faculty for evaluation. The college or faculty will assess whether the applicant's training, qualifications and experience, taken as a whole and mapped against the relevant CCT curriculum and assessment system, are sufficient to demonstrate equivalence in the relevant specialty. A recommendation is then made to the GMC. It is for the GMC to decide whether to accept the recommendation and award a CESR or CEGPR. In around 99% of cases the College recommendation is accepted. The process is summarised in the diagram in Appendix 1.

Section 2: Remit of the review

20 Lord Patel's review provided the impetus for the GMC to examine the arrangements inherited from PMETB to ensure that they remain fit for purpose.

21 The terms of reference for the review are at Appendix 2. Our task was to:

- examine the purpose of the equivalence routes
- make recommendations regarding the arrangements for evaluating equivalence having regard to the robustness, consistency and efficiency of existing arrangements
- evaluate current perceptions of the equivalence routes and the extent to which they are treated as equivalent to the CCT
- make recommendations regarding the suitability of the existing legal and administrative framework relating to the award of CESRs and CEGPRs.

22 But, above all, our primary and overriding consideration has been to ensure that patients and the public can have confidence in the standards applied through these routes for entry to the specialist register and the GP register. This is reflected in the working principles for the review which we developed to support our terms of reference and serve as a template against which we could test our developing ideas (Appendix 3).

Section 3: Working methods

23 A working group including representatives of all the principal stakeholders was established to undertake the review (Appendix 4).

24 The group's discussions were informed by a wider range of views. In May 2011 we ran a seminar for Staff and Associate Specialist (SAS) grade doctors at which we discussed the current CESR/CEGPR process and explored ideas for how it might be improved.

25 In addition, research was commissioned from Zircadian Consulting into perceptions of the CESR/CEGPR routes. This built on earlier research undertaken by PMETB in 2008. The Zircadian report setting out the results of the recent research can be found on the GMC website at **www.gmc-uk.org/about/research/12023.asp**. Discussion of the principal findings is provided in section 5 of this report.

26 We also spoke individually to representatives from a number of the colleges; in particular the Royal College of Surgeons of England, the Joint Royal Colleges of Physicians' Training Board and the Royal College of Anaesthetists. We are grateful to the Royal College of Anaesthetists for the opportunity to observe the work of its CESR Equivalence Committee.

27 The working group met on five occasions between February and December 2011. The group's recommendations are set out in this report. They are intended to provide the basis for a full public consultation on proposals for a new model for CESR/CEGPR applications.

Section 4: Understanding the problem

Statistics and outcomes

28 The current CESR/CEGPR arrangements were put in place in 2005. Between 2005 and 2010 a total of 3,910 applications were determined. Of these, 2,824 applications were successful. CEGPR applicants are more likely to be successful (96%) than CESR applicants (60%). This is mainly because most would have been appointed to a training programme and therefore able to demonstrate that they had met the curriculum requirements even though they were ineligible for a CCT. A more detailed statistical breakdown of applications is provided in Appendix 5.

29 There is a continuing demand for an alternative route to the GP and specialist register for doctors who are not eligible for a CCT. We have been impressed by the diligence, expertise and commitment of the individuals and organisations working to support the CESR/CEGPR process in response to that demand.

30 However, our review identified features of the current arrangements which are contributing to negative perceptions of CESR/CEGPR routes.

The burden of documentation

31 The most notable feature of the current system is that the assessment of doctors' specialist competence relies exclusively upon documentary evidence submitted by the applicants and their referees. This includes, but is not limited to, CVs, copies of certificates of specialist qualification, details of curricula leading to specialist qualifications, references and testimonials, log books, details of honours and prizes, copies of appraisals and assessments, evidence of feedback from colleagues and patients, personal development plans, job descriptions, CPD records, details of presentations and publications, memberships of professional organisations, evidence of teaching and audit.

32 Because this is an evaluation of applicants' experience overall the GMC cannot put a limit on what may be submitted. Equally, it is not in applicants' interests to limit what they send. The material frequently runs to many hundreds of pages, and, on some occasions, over a thousand. Much of this has to be authenticated at source.

33 This reliance on documentation places a considerable burden on all those involved in the process. Despite this, the biggest single reason that applications fail is because the evidence submitted is incomplete.[6] Once an application is received, the process takes between six and nine months before a decision is reached.[7] The burden on the GMC and the medical royal colleges involved in evaluating this volume and diversity of material is considerable. Although the application fees have recently been reduced, the financial cost to applicants is still significant.[8]

Nature of the evaluation

34 More importantly, although the evaluations of the evidence carried out by the colleges and the GMC are painstaking and meticulous they depend, in large part, upon judgements of paper based evidence. Much of this paperwork will have been generated originally for entirely different purposes. Our review group received evidence of the difficulty of assessing this material in the context of a CESR or CEGPR application, particularly when it related to experience acquired outside the UK.[9] In contrast, the assessment systems for the equivalent CCTs require elements such as national professional examinations and completion of workplace based assessments.

35 We wish to stress, however, that we saw no evidence to suggest that the current arrangements have led to harm to patients as a result of CESR/CEGPR applicants being inappropriately included in the GP or specialist registers. They are not disproportionately represented in the GMC's fitness to practise proceedings. Nor did research carried out to support this review point to concerns among employers or other doctors about the subsequent performance of successful applicants, despite a preference for the CCT as the 'gold standard'.[10] We did, though, encounter the perception that CESR/CEGPR holders find it more difficult to progress in their subsequent careers than CCT holders,[11] though the reasons for this may be complex and not entirely related to the type of certification they have achieved.[12]

Process design: certification panels and specialist advice

36 During the course of the review we noted concerns expressed by some of the medical royal colleges about the CESR/CEGPR process. These related to the interactions between the colleges and the GMC in determining applications and the burden on college evaluators. There was also criticism of some GMC decisions not to follow college recommendations on individual cases. While such cases represent a very small proportion of the number of applications considered,[13] they contribute to negative perceptions about the route and serve to undermine college confidence in the process.

Legislative constraints

37 The introduction of the current CESR/CEGPR arrangements in 2005 under PMETB made the equivalence routes accessible to a wider range of applicants. This was partly because it became possible to take account of applicants' professional experience as a whole and not just their training and experience. Further, the routes were no longer limited, as they had been previously, to doctors with overseas specialist qualifications.

38 But in other respects the legislation continues to impose unhelpful constraints. Those constraints fall into two broad categories: constraints imposed solely by UK law and those dictated by European law. Had we confined our review to considering only those aspects of the CESR/CEGPR process which could be changed without amendments to legislation the opportunity for making improvements would have been limited to minor tinkering around the edges of the current system. We have therefore tried to take a longer term view and identify the changes that are needed to achieve more fundamental changes which are in the interests of both patients and doctors. At the same time, we wish to be realistic. While there may be opportunities to change UK law affecting the CESR/CEGPR process, securing similar change to EC law is, at best, a long term aspiration.

39 Our conclusions in this report consequently fall into three groups. Recommendations which can be implemented in the short to medium term without legislative change; recommendations requiring change to UK statute; observations on the constraints of EC law and, where appropriate, recommendations for action to ameliorate problems for which there is no immediate legislative solution. Our approach is considered in more detail in sections 6 and 8 of this report.

40 Applicants for inclusion in the specialist register in a non-CCT specialty need to have undertaken specialist training or been awarded specialist qualifications outside the UK in a non-CCT specialty, though not necessarily the one in which they are seeking equivalence. This leads to some curious anomalies and potential unfairness. We heard, for example, of UK SAS grade doctors working in lead roles in community child health (a non-CCT specialty) who were unable to apply for a CESR in their field because they had not undertaken training or obtained specialist qualifications overseas. The only options for them were to obtain qualifications or six months training overseas (even if not in the relevant specialty) or acquire further UK experience in a different field in order to be eligible to apply in a CCT specialty. The same constraints do not apply for international medical graduates. In addressing such anomalies changes to the statutory eligibility criteria would need to guard against the proliferation of CESRs in ever narrower fields.

41 A further concern voiced by many doctors related to the different forms of certification awarded depending on whether a doctor pursues the CESR/CEGPR or CCT route. Although both types of certificate confer eligibility for inclusion in the GP or specialist registers we repeatedly heard concerns voiced by SAS grade doctors that having different certificates for CESR/CEGPR holders led to them being at a disadvantage compared with CCT holders seeking consultant or GP appointments.[14] It was also felt that they were at a disadvantage when seeking recognition elsewhere in Europe, although in fact EEA recognition is not always straightforward even for CCT holders.[15] There was a strongly held view that having a single form of certification for all doctors, regardless of their route of entry to the registers, would address this problem.

42 The review working group shared the concerns of SAS grade doctors that the different nomenclature was unhelpful. We explored the scope for abolishing separate forms of certification and using inclusion in the GP or specialist register as the single regulatory currency. However, we received clear legal advice that this would be at odds with current EC law. Given the difficulty of changing European law in the foreseeable future we concluded that other solutions should be pursued in the interim to try and address adverse perceptions of the CESR/CEGPR routes. We discuss these in section 6.

The specialist register

43 Perception causes problems in other areas too. This is because inclusion in the GP and specialist register is sometimes seen as the default requirement for employment in academic posts or for the award of research grants, even where there is no such legal requirement. The review group was concerned at evidence that the CESR route was being used for purposes for which it was not intended[16] and in ways which may undermine the meaning of the specialist register.

44 This also pointed to more general problems associated with the nature and function of specialist register itself. There is no single standard for inclusion in the register. Applicants for CESRs in academic and research fields will demonstrate a much narrower range of competencies than those in CCT specialties. Similarly, the evidence requirements for doctors in non-CCT specialties differ from those in CCT specialties. Since there is no CCT curriculum or assessment system against which their competencies can be mapped they are evaluated against those parts of the curriculum and assessment system which relate to their specialty, combined with generic criteria. This contributes to the confusing picture of a specialist register which lists over 300 specialties[17], only around 61 of which are recognised in the UK.[18]

45 The review group recognised that these characteristics of the specialist register were beyond the scope of the present review, though they have constrained us in the way we have had to address the problems associated with the CESR/CEGPR process. The group therefore urges the GMC to look again at the fitness for purpose of the specialist register.

Foundation Trusts and the specialist register

46 In the footnote to paragraph 5 of this report we note that Foundation Trusts in England are exempt from the legal requirement that applies elsewhere for doctors to be on the specialist register in order to be appointed to consultant positions. We consider this to be a loophole which undermines the purpose of the specialist register and can contribute to uncertainty about the standards required for consultant appointments across the UK. We consider that this is not in the interests of patients or the public.

Section 5: Dealing with the perceptions of others – research by Zircadian Consulting

47 The Zircadian research looked at how employers, the colleges and different groups within the profession understood and perceived the CESR/CEGPR routes. This was important given the reports we received that CESR/CEGPR holders consider themselves at a disadvantage when competing with CCT holders for consultant and GP appointments.[19] More generally, understanding perceptions would enable us to gauge the credibility among stakeholders of the regulatory tools the GMC is using. The full report of the Zircadian research can be found at und at **www.gmc-uk.org/about/research/12023.asp**. The key conclusions reached by Zircadian are summarised in the bullet points below.

Relationship between the GMC and Royal colleges/faculties

- There are some tensions between the GMC and the royal colleges/faculties regarding the CESR/CEGPR evaluation processes, particularly regarding discrepant decisions, border-line cases and the type of evidence required. There is an ongoing programme of work by the GMC to improve communications and collaboration with the colleges and faculties.

Application and evaluation process

- The CESR/CEGPR application and evaluation process is viewed as difficult, overly complex and bureaucratic by the profession.
- Overall, there is a view that the CESR/CEGPR process needs to be streamlined, the quality of evidence gathering and presentation needs to be simplified and improved, and the submission methods updated.
- Some of the royal colleges expressed an opinion that CESR/CEGPR applicants should be required to sit a test of clinical competence or be interviewed to validate their experience.
- Some of the royal colleges expressed an opinion that a CESR/CEGPR applicant who has not worked in the UK should be required to work for six months with some element of supervision, review and assessment of competence.
- The royal college and faculty evaluators are essentially unpaid volunteers who often perform evaluations in their own time. There is a need to professionalise this cadre of senior doctors and recognise their contribution.

Awareness of certification routes

- Many doctors are unaware of, or do not understand, all the routes to certification. Overall, 31% of all doctors were only aware of the CCT route to certification and only 22% were aware of all the routes. Foundation trainees are particularly unaware of the routes to certification.

Views of the different routes to certification[20]

- Colleges universally stated that they regard the CESR/CEGPR certificate as equivalent to the CCT certificate.

- The views of the profession largely support the equivalence of CESR/CEGPR to CCT. However, some preference for CCT over and above CESR/CEGPR was expressed.

- CCT is widely regarded as a robust certificate by most doctors. It is the personally preferred route to certification for 70.4% of trainees, 51.3% of SAS doctors and 46.2% of certificate holders. Around one fifth of certificate holders, and one quarter of trainees responded that CCT holders were the more clinically capable (related to the structured competency based training programme and robust assessments of clinical ability). Overall, both certificate holders and trainees felt that CCT holders benefit from being: selected for training through a competitive process; younger and 'on the ladder' at an earlier stage; able to build better networks; better equipped to progress; probably more competitive and ambitious; and, as a result favoured by employers for the best jobs with the best career opportunities.

- In contrast to the views on CCT, CESR/CEGPR certificates were regarded as robust by fewer doctors. However, both certificate holders and trainees also responded that CESR holders can be highly skilled and competent due to the nature of their service responsibilities and often longer experience.

- Overall, 49% of all doctors either 'agree' or 'strongly agree' that a CESR/CEGPR is a robust certificate to ensure a doctor's competence to practice as a consultant or GP without supervision.

- The view of the profession regarding overall capability of a doctor is that it is the same or unrelated to certificate route.

- The employers' view is that the CCT is the gold standard. The CESR/CEGPR gives less assurance in the standard of a doctor with over 75% of employers stating a 'preference' or 'strong preference' towards CCT holders. Employers regard them as generally more capable due to the nature of their UK training and the quality assurance of this training. There is a particular concern that those who fail to gain a CCT training position may see and use CESR/CEGPR as a back door entry to the GP or specialist register.

- There is a view that CCT holders are more likely to perform to a uniform standard, whereas CESR/CEGPR holders operate to variable standards. The variation is perceived by employers as linked to the disparate training and experiences of CESR/CEGPR doctors.

- For employers there is a perceived difference between UK trained doctors and overseas trained doctors. Some felt that the latter group should go through a period of supervised training as part of the assessment process.

- Overall, 53% of all doctors felt that the standard of a doctor's clinical capability to work at GP or consultant level was unrelated to the route of certification.

- There is particular concern that those who fail to gain a CCT training position may see CESR/CEGPR as a back door entry to the GP or specialist register.

Career progression

- The overall perception is that CCT holders may fare better than CESR/CEGPR holders when in competition for a desirable position and that the latter are more likely to be appointed to the less popular jobs with less career opportunities.

Change in view since the GMC assumed responsibility from PMETB

- The GMC has not made a measurable impact on the views of the profession and employers since taking over responsibility for CCT/CESR/CEGPR.

48 In the light of these findings, Zircadian's recommendations included:

- Consideration by the GMC of a more collaborative approach with the Royal Colleges and Faculties to alternative route evaluations.

- Further joint work by the GMC and the Colleges to recognise, respect and develop the role of the college evaluators.

- There should be a further review of the evidence required for alternative route applications. For example, the GMC could provide easier access and better communications to information and expert advice, provide a typical evidence profile to address lack of information regarding the required structure or content, removal of evidence demands that cannot be accessed or validated and manage the CESR/CEGPR prospectively, not in retrospect.

- The GMC should improve awareness in the profession and amongst employers regarding the alternative routes to certification and the evaluation processes involved.

- The GMC should consider a further research project to evaluate career progression of doctors following certification via all routes, to compare the routes in terms of substantive GP or consultant appointment and subsequent career progression.

49 Zircadian's findings were used to inform the subsequent thinking of the working group. The findings also reinforced the messages we had received from SAS grade doctors in May 2011. They had described the CESR/CEGPR process as arduous, slow, bureaucratic and expensive. They said that even successful applicants often wait a long time to be appointed to consultant posts. They expressed support for an application process with greater emphasis on the prospective gathering of supporting evidence through workplace based assessments. They wanted account taken of the amount of time and experience an applicant had acquired working in the UK. They called for the GMC to do more to promote understanding of the equivalence routes among employers. Finally, they argued that the separate CCT, CESR and CEGPR routes should lead to a single form of certification to help prevent discrimination against CESR and CEGPR holders.

Section 6: Solutions

50 The review group was in no doubt that there should continue to be routes to GP and specialist registration other than through the CCT. The need for workforce flexibility and changing medical demographics meant there were likely to be increasing numbers of doctors following non-standard career paths. Providing alternative pathways to the registers would help meet that need.

51 However, the current nomenclature of 'CCT equivalence' is unhelpful. It reinforces perceptions that the CCT provides the gold standard which other routes need to match. Therefore, it is more important to think in terms of all doctors entering the GP and specialist register having to achieve a required standard. Different routes to the registers allow doctors to demonstrate the standard in different ways. The key question for the review, therefore, was what evidence was needed to demonstrate that a doctor has met the standard and how should that evidence be evaluated?

A new model for evaluation

52 A new model for evaluating applications is needed. The model must address the widespread concerns about the burden of documentation imposed under the present system and the need for robust and credible evidence of applicants' competence.

53 Our proposed model has four stages or elements. Although described here sequentially, the elements may overlap or run concurrently.

Stage 1: Eligibility to apply: acclimatisation

54 There is currently no requirement for doctors to have been fully registered with the GMC or to have undertaken any medical practice in the UK before they can apply for a CESR/CEGPR. Yet doctors admitted to the GP and specialist registers have greater autonomy than other groups of doctors. This does not sit easily with the evidence that those who have qualified outside the UK face significant challenges in adapting to the UK context[21]. We also noted the comments made by some of the participants in the Zircadian research about the need for CESR/CEGPR applicants to have undertaken supervised practice in the UK.

55 We recommend that:

Doctors must already hold full registration and a licence to practise, and have practised in the UK as a licensed doctor for at least six months within the previous three years[22], before applying for a CESR/CEGPR.

56 The purpose of this requirement is to ensure applicants have the opportunity to acclimatise to practice in the UK and absorb and be seen to apply the principles of *Good Medical Practice*. The period of acclimatisation would not need to be in the specialty in which the doctor is seeking a CESR/CEGPR since evaluation of specialist performance could be undertaken separately (see Stage 3 described below).

57 For applicants to most specialties the requirement for a short period of acclimatisation will not create any additional burden since most will already have been practising in the UK for many years.

58 However, it will mean that international medical graduates will no longer be able to use a successful CESR/CEGPR application as a direct route into full registration and UK medical practice. The GMC will need to consider whether those applicants should be expected to use one of the existing routes to full registration (such as a pass in the PLAB test) or whether other mechanisms should be developed.

59 We recognise that under existing legislation the requirement for a period of acclimatisation would be problematic for doctors hoping to obtain a CEGPR because they would be unable to work as GPs during this time. We address this issue later in our report (see paragraphs 81-83).

Stage 2: Evidence of knowledge

60 There is currently no requirement for CESR/CEGPR applicants to sit a formal test of knowledge, although those with specialist qualifications obtained in the UK or overseas may use them as evidence to support their application. More typically, possession of the requisite specialist knowledge is inferred by evaluators from documentary evidence of experience and training.

61 The working group debated at length the question of how doctors should demonstrate their specialist knowledge and, in particular, whether a formal test of knowledge, taken in the UK, should form part of the evidence requirements for application.

62 We considered whether the use of tests of knowledge could contribute to greater objectivity in the evaluation of applicants and thereby reinforce the robustness and credibility of the process in the eyes of employers, patients and the public.

63 It was also argued that if CCT trainees were required to take examinations the same should apply for CESR/CEGPR applicants in order that the two processes could be regarded as equivalent. We recognised, however, that 'equivalent to' does not mean 'identical to' and therefore doctors might be able to demonstrate in other ways that they have achieved the necessary standard. Yet those in favour of knowledge testing maintained that assessing the application of knowledge in practice through an evaluation of performance did not equate to demonstrating the full range of specialist knowledge and understanding that could be assessed through formal testing.

64 We noted that the Zircadian research had given no indication that successful applicants lack the requisite specialist knowledge and, as we point out in paragraph 35 of this report, there is no evidence that CESR/CEGPR holders are over-represented in the GMC's fitness to practise procedures. Furthermore, there was concern about the availability of suitable tests of knowledge at the appropriate level across all specialties.

65 Where such tests exist they have been designed for individuals who have undertaken a programme of specialty training intended to prepare them for those examinations. Not all medical royal colleges currently make their assessments available to doctors who are not trainees. CESR/CEGPR applicants were therefore likely to be at a disadvantage if required to take such tests. Colleges would, therefore, need to make their assessment systems more accessible to those outside of formal training programmes in order to support the development and aspirations of CESR/CEGPR candidates.

66 The arguments on both sides were finely balanced and we were unable to reach a consensus view. The GMC may wish to test the arguments further through formal consultation.

The GMC should consult on whether a formal test of knowledge in the relevant specialty should form an essential component of any application. This should include the questions of whether it is reasonable to adopt different approaches for different specialties and whether evidence of the application of knowledge demonstrated through evaluation of actual practice and performance could substitute for a separate examination of knowledge.

Stage 3: Evaluation of practice and performance

67 The current dependence upon evaluation of documentation should be replaced by formal evaluation of performance in practice in the relevant specialty in the UK against prescribed competencies. The evaluation should be calibrated with the standards and extent of practice in the relevant specialty at the level of the final year CCT. It should also have regard to the GMC's ongoing work to develop generic outcomes for all specialty training so as to ensure that doctors entering the GP register or specialist register via the alternative routes have the same generic attributes as CCT holders appointed to consultant or GP posts.

68 The evaluation should draw on College assessment tools for the relevant specialty curriculum and include a series of mandatory assessments of performance[23] specified in the equivalent CCT for that specialty. The college should identify the number and breadth of assessment events required to evaluate performance reliably. As we have already noted, this may require some colleges to make their assessment tools more accessible to doctors who are not part of a recognised training programme.

69 In recommending the use of such workplace based assessment tools we are mindful of ongoing work by the GMC and others on their use for doctors in training and the distinction between their application for formative and summative purposes.[24] However, while the tools remain part of the assessment systems for CCTs they should not be precluded for CESR/CEGPR applicants.

70 The evaluations should take place in recognised training environments.

71 Subject to the outcome of the GMC's current work on the recognition of trainers, evaluations should be carried out by educational supervisors who are part of the relevant training programme and specialty school and who are formally recognised as trainers.[25] The evaluations should be undertaken using a range of assessors and under the auspices of the relevant postgraduate deanery function. This may require an extension of current deanery responsibilities.

72 Once a prospective applicant has completed the mandatory evaluations for the specialty the recognised trainer should make a recommendation to the GMC regarding the individual's suitability for a CESR/CEGPR. A doctor should not be eligible to apply for a CESR/CEGPR until the mandatory evaluations are successfully completed.

73 The GMC should consider how its *Quality Improvement Framework* could be used to support the quality assurance of educational supervisors' recommendations.

74 We consider that this model should also replace the current paper based applications for academic and research CESRs.

75 We consider that evaluation of performance in practice will enhance the current application process in several ways.

76 First, applicants will be able to accumulate evidence prospectively for the specific purpose of a future CESR/CEGPR application rather than being required to assemble a miscellany of material intended for other purposes.

77 Second, evidence of assessment of performance will dramatically reduce the volume of documentary evidence required to support an application. This will reduce the burden on applicants and the GMC. Moreover, since educational supervisors will make recommendations direct to the GMC the need for college evaluators to scrutinise the documentation from individual applications will be greatly reduced and possibly eliminated. This will remove the burden currently placed on unpaid college evaluators. The role of the colleges will be primarily in relation to the setting of specialty standards and the performance assessment tools to be used.

78 Third, evaluation of performance will provide a peer evaluation aimed at establishing consistency of performance at the required level over a period of time, rather than a single snapshot assessment.

79 Finally, although we did not establish a direct causal link between participation in workplace based assessments and CESR/CEGPR outcomes, we have noted that current CESR/CEGPR applicants who are able to provide evidence of workplace based assessments are more likely to be successful.

80 In the context of CESR/CEGPR applications we are, therefore, positive about the added value of directly observed evidence of practice through workplace based assessments. We, nevertheless, recognise that there are challenges to be addressed before the GMC could move to a system based on evidence of performance and that this should be the subject of consultation. While the burden on applicants, the colleges and GMC will be reduced, greater responsibility would fall on the educational supervisors making

recommendations to the GMC with the potential for appeals against unfavourable evaluations.

81 We also recognise the implications for general practice. At present, only doctors on a performers list (managed by primary care organisations) are able to work as GPs. The National Health Service (Performers Lists) Regulations require doctors to be in GP training[26] or on the GP register. Therefore, under current regulations CEGPR applicants who are not in GP training would be unable to complete the evaluation of performance in practice proposed in our new model. This is likely to have a particular impact on international medical graduates who are new to UK medical practice. We nevertheless consider that it is in the interests of patients and the public that doctors seeking inclusion in the GP register should be subject to an evaluation of their performance in their chosen field as they would be in any other specialty.

82 Full implementation of our proposed model will therefore require work with stakeholder organisations to amend the Performers List Regulations. The aim would be to enable CEGPR applicants to work in general practice training environments which include suitable arrangements for their supervision and assessment.

83 We recommend that:

Successful application for a CESR/CEGPR should require an evaluation of performance in practice in the relevant specialty in the UK against prescribed competencies.

Relevant statutory regulations should be amended to enable CEGPR applicants to undergo evaluation of their performance in practice in training environments which include suitable arrangements for their supervision and assessment.

Stage 4: Evaluation of documentary evidence of experience

84 The proposed model will reduce the volume of documentary evidence currently required from applicants. Evidence should be limited to demonstrating aspects of knowledge and experience mapped against the relevant curriculum requirements which have not been separately demonstrated through a formal college test of knowledge or evaluation of performance. If an applicant has passed an appropriate test of knowledge, there would be no need to provide additional documentary evidence of knowledge.

85 The GMC will need to agree with the colleges the documentary evidence requirements for each specialty in the light of mandatory performance assessments identified for the relevant specialty.

86 We recommend that:

The documentary evidence of knowledge and experience required should concentrate on those areas of the curriculum that have not been addressed by the applicant through the other elements of the evaluation model.

87 We further recommend that:

The new evaluation model should also replace the current paper based applications for academic and research CESRs.

88 A diagram summarising the proposed model is provided at Appendix 6.

Eminent overseas doctors

89 Each year the GMC receives a small number of applications for specialist registration from figures of high international standing who are recognised as eminent in their field and who wish to take up senior clinical or academic posts in the UK. Specialist registration is usually a requirement for their UK post, but they are ineligible for a CCT. The CESR application process is therefore their only route into UK medical practice.

90 The working group acknowledged the benefits that such expertise may bring to UK healthcare and UK patients. It is important that the regulatory process is not constructed so as to deter figures of genuine standing and renown from bringing their skills to the UK. At the same time, the GMC has a duty to satisfy itself of the capability for practice at the required level of doctors admitted to the registers.

91 Requiring such individuals to undergo a period of acclimatisation and evaluation of performance in practice is likely to create a significant deterrent for entering UK medical practice. Bearing in mind the very small number of cases involved, we consider that it would be appropriate for them to be evaluated on the basis of documentary evidence alone. However, that evidence must be capable of providing the GMC with a very high level of assurance. Appendix 7 lists the eligibility criteria and documentary evidence that should be required to support such an application.

92 We recommend that:

Individuals of high international renown and expertise in their field should not be required to undergo an evaluation of their performance in UK medical practice. Their eligibility for a CESR should, instead, be assessed on the basis of documentary evidence of their credentials as described in Appendix 7.

Process design: certification panels and specialist advice

93 Some of the recommendations in this report will need time to implement and require legislative change. In the interim, we wish to address a number of the features of the current evaluation process which have been identified as giving cause for concern.

94 The feedback from the Zircadian research included criticism that the GMC has sometimes not followed college recommendations about applicants' suitability to be awarded a CESR or CEGPR.[27] This has been coupled with concern that the GMC certification panels which receive any contested recommendations do not necessarily include representatives from the relevant specialty and may therefore be ill-equipped to consider questions relating to specialist matters.

95 Statutory responsibility for including a doctor in the GP or specialist register rests with the GMC. It is therefore right that the Registrar of the GMC retains discretion to accept or reject the expert advice and recommendations received from those who evaluate applications. The Registrar must also be able to explain his or her decision. The way that discretion is exercised must, therefore, be robust and transparent if the system is to command the confidence of applicants and evaluators and, above all, the public. There are a number of steps the GMC and the colleges should take.

96 College recommendations may be questioned for a number of reasons: where the recommendation is not fully substantiated by reference to the relevant evidence; where it has not been mapped against the relevant CCT curriculum or assessment blue print; where the recommendation is unclear or does not appear to reflect the applicant's evidence. Experience shows that points of contention are more likely to be resolved where the GMC is able to engage directly with the college evaluators. But such direct engagement has not always been possible. We therefore recommend:

That the GMC and colleges should explore together how direct engagement between the GMC and college evaluators can be facilitated in order to minimise the need for the GMC to seek advice on an application from a certification panel.

97 Where points of contention cannot be resolved and an application must be referred to a GMC certification panel, there needs to be greater transparency about the role of the panel. It is not the function of GMC panels to substitute their specialist expertise for that of the college evaluators. Given that a panel will not always include a doctor from the applicant's specialty they may not have the necessary specialty expertise to do so reliably. We consider:

That the task of the panel should be to advise the Registrar as to whether the evaluators have, in reaching their judgement, properly applied the published standards, curricula and assessment blue print applicable to the case and evidenced their conclusions by reference to the documentation submitted by the applicant. The question for the panel is not whether it prefers its own opinion to that of the college evaluators, but whether the evidence cited by the evaluators supports the conclusions of the evaluation as reasonable and properly made.

Where the GMC is minded not to accept a college recommendation it should take independent specialist advice at an early stage so as properly to inform any subsequent deliberations by a certification panel and the Registrar. GMC specialist advisors should have direct access to college evaluators.

The GMC should review the size, composition and meeting arrangements of panels necessary for them effectively to fulfil their functions. This should include looking at the opportunities for reducing the size of panels and the frequency with which they sit. It should also examine the case for improving the consistency and efficiency of panel decision making by having a single chair and a smaller pool of panellists who are able to maintain their skills through regular involvement in the process.

Published terms of reference should ensure that the role and composition of certification panels and the role of specialist advisors are transparent and accessible.

98 We consider that the new evaluation model we have recommended will greatly diminish the need for certification panels.

Improving understanding and changing perceptions

99 The Zircadian research pointed to a lack of awareness, and some misunderstanding, about the CESR/CEGPR process among key stakeholders. This contributes to some of the negative perceptions about the routes. We noted earlier in this report (paragraphs 41–42) the concerns about the different forms of certification for CCT and CESR/CEGPR and their status elsewhere in Europe. We were also concerned at reports of advertisements for substantive consultant positions which specified possession of a CCT as a prerequisite for employment.

100 We consider that our proposed new model for evaluating applications will help to enhance the robustness and credibility of the CESR/CEGPR process and help to change perceptions. Changes in medical demographics and increasing numbers of doctors pursuing non-CCT career paths may also help to improve familiarity with, and therefore acceptance of, CESRs and CEGPRs. But such changes will take time. The GMC should therefore work with stakeholders, such as the Colleges, deaneries and employer organisations to improve the visibility and understanding of the CESR/CEGPR process among doctors, employers and contractors of doctors' services.

We recommend that:

The GMC should put in place a comprehensive communication plan aimed at promoting the visibility and wider understanding of the CESR/CEGPR process. It should also publish an annual report on the outcomes, issues and learning points from CESR/CEGPR applications.

Notes of caution

101 The GMC is rightly keen to ensure that the CESR/CEGPR process provides an accessible and credible alternative to the CCT. However, the credibility will be damaged if the accessibility of the route allows it to become perceived as a 'back door route'[28] to the GP register or specialist register for doctors who have demonstrably failed to meet the requirements for a CCT.

102 Care must be taken to ensure that the rules regarding admissibility of evidence of competence and performance within the CCT process must also apply to the use of that same evidence within the alternative routes. Thus, if the shelf-life for an examination within a CCT is set at a particular point an applicant who is unable to use the examination as evidence for progression towards a CCT should also be unable to rely on that examination evidence as the means of demonstrating competence for the purposes of a CESR/CEGPR. Similarly, an individual who has demonstrably failed to pass an examination required as part of the CCT must be required to provide compelling and overriding alternative evidence to offset the previous evidence of failure.

Unfinished business

103 Our review has highlighted a number of issues which require further consideration by the GMC, but which we have been unable to address within our terms of reference.

104 We have noted earlier in this report our concern about the fitness for purpose of the specialist register. The effect of the register sometimes distorts the CESR/CEGPR process and the way it is used by applicants.

105 Doctors included in the specialist register are eligible to apply for the inclusion of a recognised sub-specialty in the register. There is no concept of a sub-specialty CESR. We were clear that this merited examination, but noted that it is shortly to be considered as part of a more wide ranging review of specialties and sub-specialties within training rather than as something exclusive to the CESR process. We hope that the forthcoming review of the shape of postgraduate training will address the issue, building on the earlier work of PMETB in 2010.[29]

Section 7: Equality and fairness

106 Our review has sought to ensure that the CESR/CEGPR routes provide a robust but fair, proportionate and accessible mechanism for obtaining GP registration and specialist registration. The recommendations aim to enhance the credibility of the system, and therefore the standing of those who have a CESR/CEGPR certificate. A significant proportion of applicants and certificate holders are from groups who share protected characteristics which are covered by equality legislation (see statistical profiles in Appendix 5).

107 We found no evidence that the existing process discriminates against particular cohorts of doctors, or has resulted in doctors being inappropriately admitted to the registers. However, it is clearly bureaucratic, burdensome and overly dependent upon review of documentary evidence of experience instead of a robust evaluation of current performance.

108 The current process is not well regarded by applicants and is poorly understood by employers and the profession generally. Doctors holding CESRs/CEGPRs have argued that they are at a disadvantage when competing for posts with CCT holders and seeking employment in Europe.

109 The GMC has a duty to consider how the regulatory tools it deploys will affect people from protected groups and to ensure that those tools command confidence among our stakeholders. The main issues in this regard are the profile of, and outcomes for doctors involved in the CESR/CEGPR process; whether the shift towards formal evaluation of performance in practice disadvantages any group of doctors; and ensuring that any evaluation is fair and robust.

110 The review has confirmed that there should continue to be alternative routes to GP and specialist registration in addition to the CCT. Different routes to the registers allow doctors to demonstrate that they meet the required standards in different ways. They also recognise the increasing number of doctors following non-standard career paths.

111 Some doctors have argued that a single form of certification would help to prevent discrimination against CESR/CEGPR holders. We have given this careful consideration but have received clear legal advice that this would be at odds with current EC law. This is covered in more detail in paragraphs 41-42.

112 The new evaluation model we have proposed in this report will remove much of the documentary burden on applicants while providing a more objective evaluation of current performance. We consider that this will help to enhance the credibility of the CESR/CEGPR process. It will be fairer to applicants because they will know from the outset which evaluations they will need to complete and

may help increase the status of the certificates they are awarded. We believe that the proposed changes will also provide greater accessibility of information and transparency about how decisions are made.

113 Feedback from doctors in some of the key groups affected by the process suggests support for the sort of approach we are proposing[30], although this will need to be tested more thoroughly through formal consultation with a much wider group of stakeholders.

114 Our review has identified that work is needed to change perceptions of the CESR/CEGPR routes. Changing the process in the ways recommended in this report will help. But this must be accompanied by proactive steps on the part of the GMC and its partners to improve understanding of the status of the route among stakeholders. The recommendation in paragraph 99 is intended to address this need.

Section 8: Legislation

115 In Section 4 of this report we described some of the legislative constraints within which the current CESR/CEGPR process operates and the anomalies that this creates. We acknowledge that some of these, particularly those imposed as a result of European law, are unlikely to be addressed in the short or medium term.

116 However, work led by the Law Commission is underway to reform UK legislation affecting healthcare regulation. One of the aims of that work is to give regulators greater operational flexibility and autonomy. This should provide the opportunity to address the sort of anomalies identified in section 4 of this report. The Law Commission's work is expected to conclude in early 2015.

117 We have also noted the need for amendments to the National Health Service (Performers Lists) Regulations, without which key elements of our new evaluation model could not be introduced for doctors seeking to work in general practice.

118 The need for legislative change should not, however, prevent the GMC from making progress to reform the current CESR/CEGPR process. Work on improved engagement with the medical royal colleges and better use of specialist advice, the use of evaluation of performance in practice, the reduction in the level of documentary evidence required from applicants, changes to the handling of applications from individuals of international renown and work to improve the transparency and understanding of the process could all proceed in the interim.

Conclusion

119 For the equivalence routes to the GP register and the specialist register to command the confidence of stakeholders they must meet a number of tests. The overriding priority is the interests of patients and the public and to this end the process must provide a robust and reliable evaluation of an individual's knowledge, skills and performance at the required level. But the process must also be fair and proportionate in what it requires applicants to demonstrate, as well as practical and accessible. The new evaluation model recommended in this report attempts to strike that balance.

120 We are conscious that although much can be improved now, full implementation of the model may be some way off. Changes to legislation will be required. Work is also needed with individual medical royal colleges and faculties on the proposed mandatory assessments of performance and with employers and deaneries to pilot how those assessments would operate locally to provide recommendations to the GMC about individuals' suitability for registration.

121 We are also mindful that the structures for delivering health services and training are changing. It is not yet clear how some of these changes might affect the detail of how our proposed model is rolled out.

122 But it was necessary for us to look beyond what is possible today if we were to meet the tests we had set ourselves at the outset of this review. This report establishes the principles and framework upon which the GMC should now build.

List of recommendations

- Doctors must already hold full registration and a licence to practise, and have practised in the UK as a licensed doctor for at least six months within the previous three years[31], before applying for a CESR/CEGPR (paragraph 55).
- The GMC should consult on whether a formal test of knowledge in the relevant specialty should form an essential component of any application. This should include the questions of whether it is reasonable to adopt different approaches for different specialties and whether evidence of the application of knowledge demonstrated through evaluation of actual practice and performance could substitute for a separate examination of knowledge (paragraph 66).
- Successful application for a CESR/CEGPR should require an evaluation of performance in practice in the relevant specialty in the UK against prescribed competencies (paragraph 83).

- Relevant statutory regulations should be amended to enable CEGPR applicants to undergo evaluation of their performance in practice in training environments which include suitable arrangements for their supervision and assessment (paragraph 83).

- The documentary evidence of knowledge and experience required should concentrate on those areas of the curriculum that have not been addressed by the applicant through the other elements of the evaluation model (paragraph 86).

- The new evaluation model should also replace the current paper based applications for academic and research CESRs (paragraph 87).

- Individuals of high international renown and expertise in their field should not be required to undergo an evaluation of their performance in UK medical practice. Their eligibility for a CESR should, instead, be assessed on the basis of documentary evidence of their credentials as described in Appendix 7 (paragraph 92).

- That the GMC and Colleges should explore together how direct engagement between the GMC and College evaluators can be facilitated in order to minimise the need for the GMC to seek advice on an application from a certification panel (paragraph 96).

- That the task of the panel should be to advise the Registrar as to whether the evaluators have, in reaching their judgement, properly applied the published standards, curricula and assessment blue print applicable to the case and evidenced their conclusions by reference to the documentation submitted by the applicant. The question for the panel is not whether it prefers its own opinion to that of the College evaluators, but whether the evidence cited by the evaluators supports the conclusions of the evaluation as reasonable and properly made (paragraph 97).

- Where the GMC is minded not to accept a College recommendation it should take independent specialist advice at an early stage so as properly to inform any subsequent deliberations by a certification panel and the Registrar. GMC specialist advisors should have direct access to College evaluators (paragraph 97).

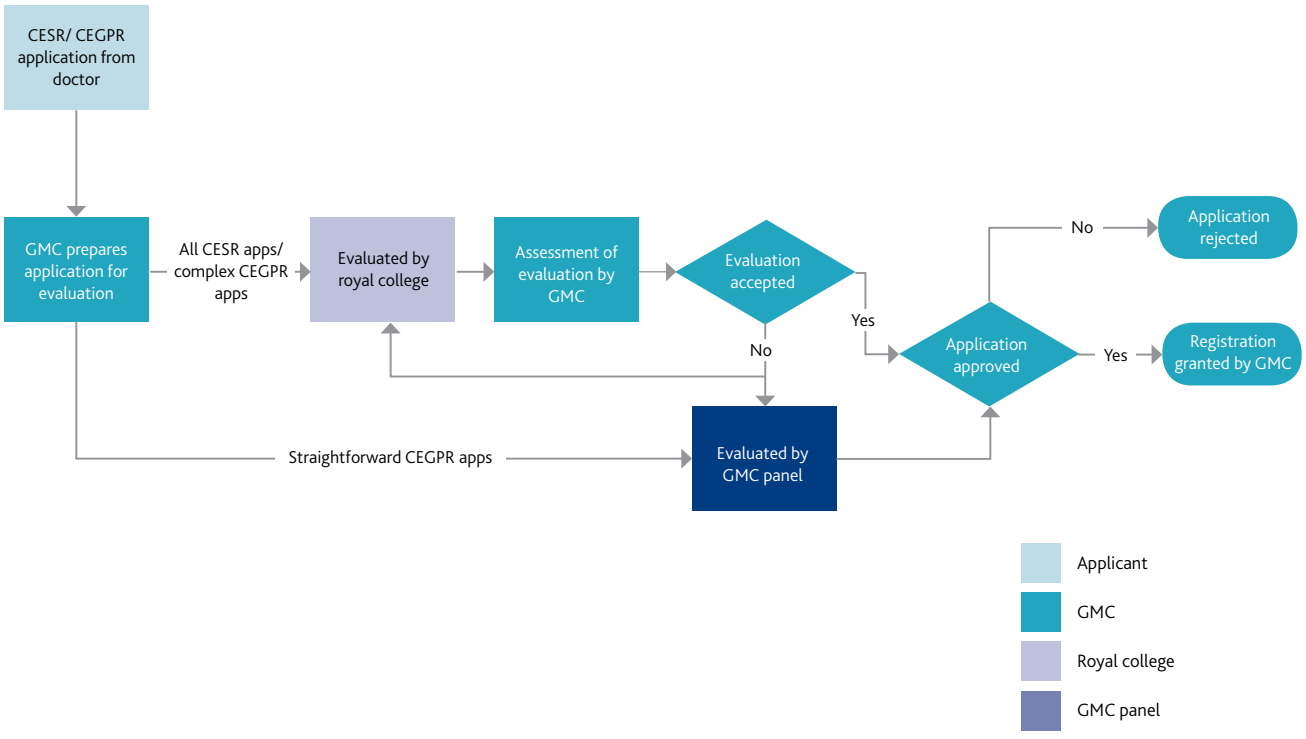
- The GMC should review the size, composition and meeting arrangements of panels necessary for them effectively to fulfil their functions. This should include looking at the opportunities for reducing the size of panels and the frequency with which they sit. It should also examine the case for improving the consistency and efficiency of panel decision making by having a single chair and a smaller pool of panellists who are able to maintain their skills through regular involvement in the process (paragraph 97).

- Published terms of reference should ensure that the role and composition of certification panels and the role of specialist advisors are transparent and accessible (paragraph 97).

- The GMC should put in place a comprehensive communication plan aimed at promoting the visibility and wider understanding of the CESR/CEGPR process. It should also publish an annual report on the outcomes, issues and learning points from CESR/CEGPR applications (paragraph 100).

Appendices

Appendix 1: Understanding the current process



Appendix 2: Terms of reference

Background

1 The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 established new routes to inclusion in the specialist register and GP register for doctors who were not eligible for a Certificate of Completion of Training (CCT) but who could demonstrate equivalent training, qualifications and experience to that required for a CCT. Originally referred to as 'Article 11' and 'Article 14' applications (after the relevant Articles of the 2003 Order) they are now referred to by the title of the certificate awarded to successful applicants: Certificate of Eligibility for Specialist Registration (CESR) and Certificate of Eligibility for General Practice Registration (CEGPR).

2 In October 2009 a PMETB working group completed a review of the CESR route 'to see if the processes needed to be improved, streamlined and modernised in the light of changes to legislation and the experience of the process to date'. As a result, a number of changes were made to existing processes. However, the limitations of legislation meant that the review was constrained from looking more broadly at the fitness for purpose of the equivalence routes.

3 In March 2010 the report of Education and Training Regulation Policy Review (the 'Patel Report') noted that the merger of the PMETB with GMC provided an opportunity to look at the scope for further improvement. It noted, in particular, concerns about the documentary requirements and means of assessment for obtaining a CESR/CEGPR. It recommended:

'Following merger, the GMC should review the processes leading to the award of CESRs and CEGPRs to ensure they are fair, efficient and fit for purpose, and that the processes continue to ensure standards are maintained.'
(Recommendation 15)

4 Subsequently, issues have arisen relating to the perception of and confidence in CESRs/CEGPRs among doctors and employers, and the recognition of these certificates in the UK and overseas.

5 In the light of these considerations, the Council of the GMC has accepted the recommendation of the Patel Report and has commissioned further work to explore the issues further.

6 As part of the GMC's ongoing work on business improvement following the merger, steps are already underway to review and streamline operational processes within the existing legislative and policy framework.

7 Focus is now required on the fitness for purpose of the underlying policy and legislative framework. But the starting point for the review is that there should continue to be routes to inclusion in the specialist register and GP register other than through the completion of a CCT training programme.

Purpose

9 The purpose of the review must be to ensure that the equivalence routes can command the confidence of all key interests by being fair, efficient and fit for purpose, and by ensuring that standards are maintained.

Key tasks

10 Building on the earlier PMETB review, the key tasks are to consider and make recommendations in relation to the following areas:

Theme 1: Clarifying the purpose of the equivalence routes

11 To examine the purpose of having alternative routes to inclusion in the specialist register and the GP register, whether it remains the same as when they were originally established and to make recommendations for any changes to the existing routes.

Theme 2: Ensuring standards

12 To make recommendations as to the future arrangements for evaluating equivalence, having regard to the robustness, consistency and efficiency of existing arrangements.

Theme 3: Confidence and equality

13 To assess current perceptions of the equivalence routes, the evidence of the extent to which they are accorded equal status to CCTs and the nature of any impediments to their equivalence. In the light of this, to identify what steps the GMC might take, or encourage others to take, to support better recognition of a robust equivalence route.

14 This section of the review should also look at the burden on applicants (including the cost of applying and the supporting documentation).

Theme 4: The legal and administrative framework

15 In the light of the conclusions from themes 1-3, to make recommendations regarding the suitability of the existing legal and administrative framework relating to the award of CESRs and CEGPRs.

Outputs

16 A written report setting out conclusions in respect of each of the key areas described in themes 1-4.

Review membership

17 The review will be taken forward by a working group comprising:

- **a** Working Group Chair (ideally someone who has considerable experience of the development and operation of the current equivalence routes)
- **b** not less than four members of Council overall (including the Chair of the Postgraduate Board)
- **c** non-GMC member(s) of the PG Board (where not represented through other key interests on the group)
- **d** two representatives from the medical royal colleges (nominated by the Academy)
- **e** COPMED representative
- **f** one employer representative
- **g** one representative from the BMA SAS grade doctors committee
- **h** Chair of a GMC Certification Panel
- **i** trainee
- **j** GMC staff representative.

Working methods

18 To be determined by the review group.

Accountability

19 The working group is expected report to the Postgraduate Board of the GMC in summer 2011.

Appendix 3: Guiding principles for the review

1 At its first meeting in February 2011 the working group identified some guiding principles against which we might test the eventual conclusions of our review.

Patient and public interest: The primary and overriding consideration in the design of the equivalence routes must be to ensure that patients and the public can have confidence in the standards applied through these routes for entry to the specialist register and the GP register.

Objectivity: Evaluation of equivalence must be based primarily upon objective evidence of generic skills and current performance in the relevant field.

Fairness: The mechanisms for determining equivalence must be equitable in providing objective, reliable and consistent decisions regarding eligibility for specialist or GP registration.

Proportionality: The requirements for applications must be proportionate and demonstrably add value to the objective evaluation of eligibility.

Accessibility: The evidential requirements must ensure that the equivalence routes must remain practical and accessible.

Equality: Any proposed model must have regard to considerations of equality and diversity.

Appendix 4: Working group members

Stuart Macpherson (Chair)

Jane Dacre (GMC)

Shree Datta (BMA Junior Doctors' Committee)

Jill Edwards (Academy of Medical Royal Colleges)

Derek Gallen (UK Foundation Programme Office)

John Jenkins (GMC)

Malcolm Lewis (GMC)

Patricia Le Rolland (GMC)

Jim McKillop (GMC)

Joan Martin (GMC)

Andrew Matthewman (Department of Health, England)

Chris Munsch (Academy of Medical Royal Colleges)

Jane Reynolds (GMC Certification Panel Chair)

Radakrishnan Shanbhag (BMA SAS Doctors' Committee)

Iqbal Singh (GMC)

David Sowden (Conference of Postgraduate Medical Deans)

John Smith (GMC)

Hamish Wilson (GMC)

Appendix 5: Certification statistics

Background

The following data is drawn from information PMETB collected from applicants until March 2010. From 1 April 2010 the GMC has collected this information.

The GMC has records of an individual doctor's sex, date of birth and, in most cases, ethnicity. The information on the country of primary medical qualification (PMQ), age and gender of doctors is information that the GMC holds for all doctors who are on the register. The information on ethnicity is less comprehensive. We currently hold ethnicity data for 74% of doctors on the register. As a result these figures do not show the ethnicity of every doctor who has been through the certification process.

Key findings

- More women than men apply to join the GP register via the equivalence route. This is mirrored in the figures for CCT applicants to the GP register.
- In relation to the specialist register more men than women join this register both through the equivalence route and via the CCT route.
- The statistics clearly show that older doctors, those over 50, use both the CCT routes and the equivalence routes but that in the 60 to 80 age bracket doctors are much more likely to use the equivalence route than the CCT route.
- The two highest reported ethnicities for applicants to the specialist and GP registers are white and Asian. Whereas for CCT applicants White is the highest reported ethnic background, for the equivalence routes it is Asian.
- Success in obtaining a CESR or CEGPR appears unrelated to ethnicity.

Gender

CCT General Practice

	Man	Woman	Grand Total
Years	Success	Success	
2005	110	181	291
2006	827	1087	1914
2007	878	1162	2040
2008	820	1120	1940
2009	962	1130	2092
2010	914	1320	2234
Grand Total	**4511**	**6001**	**10511**
Approx %	**43%**	**57%**	

CCT Specialty

	Man		Woman	Grand Total
Years	Reject	Success	Success	
2005	1	442	205	648
2006		1709	927	2636
2007		1829	1093	2922
2008		2005	1231	3236
2009		2040	1301	3341
2010		2054	1348	3402
Grand Total	**1**	**10080**	**6106**	**16185**
Approx %	**0.006%**	**62%**	**38%**	

CEGPR

	Man		Woman		Grand Total
Years	Reject	Success	Reject	Success	
2005	3	49	4	37	93
2006	11	241	5	250	507
2007	4	123	1	197	325
2008	1	83	8	146	238
2009	3	40	5	78	126
2010	2	16	2	36	56
Grand Total	**24**	**552**	**25**	**744**	**1345**
Approx %	1.8%	41%	1.9%	55%	

CESR

	Man		Woman		Grand Total
Years	Reject	Success	Reject	Success	
2005	288	329	54	48	719
2006	258	294	53	74	679
2007	152	203	31	70	456
2008	68	141	19	57	285
2009	64	156	28	55	303
2010	16	73	6	23	118
Grand Total	**846**	**1196**	**191**	**327**	**2560**
Approx %	33%	47%	7%	13%	

Place of PMQ

CCT General Practice

	2005	2006	2007	2008	2009	2010	Grand Total	Approx %
Place of PMQ	Success	Success	Success	Success	Success	Success		
EEA	43	168	221	174	174	174	952	6%
IMG	174	823	870	1049	1084	1149	5151	32%
UK	430	1645	1831	2013	2083	2081	10084	62%
Grand Total	**647**	**2636**	**2922**	**3236**	**3341**	**3402**	**16185**	

CCT Specialty

	2005	2006	2007	2008	2009	2010	Grand Total	Approx %
Place of PMQ	Success	Success	Success	Success	Success	Success		
EEA	11	88	71	61	66	52	349	3%
IMG	82	585	641	511	618	462	2899	28%
UK	198	1241	1328	1368	1408	1720	7264	69%
Grand Total	**291**	**1914**	**2040**	**1940**	**2092**	**2234**	**10511**	

CEGPR

	2005		2006		2007		2008		2009		2010		Grand Total	Approx %
Place of PMQ	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success		
EEA	1	5	2	37		35	2	22	2	15	1	3	125	9%
IMG	4	46	10	229	4	101	3	54	3	30	2	16	502	37%
UK	2	35	4	225	1	184	4	153	3	73	1	33	718	53%
Grand Total	**7**	**86**	**16**	**491**	**5**	**320**	**9**	**229**	**8**	**118**	**4**	**52**	**1345**	

CESR

	2005		2006		2007		2008		2009		2010		Grand Total	Approx %
Place of PMQ	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success		
EEA	15	13	23	8	15	12	11	14	12	10	3	3	139	5%
IMG	305	332	270	313	147	215	70	148	76	169	17	75	2137	83%
UK	22	32	18	47	21	46	6	36	4	32	2	18	284	11%
Grand Total	**342**	**377**	**311**	**368**	**183**	**273**	**87**	**198**	**92**	**211**	**22**	**96**	**2560**	

CEGPR and CESR success and failure percentages

App Type	Place of PMQ	Outcome	Total	Approx %
CEGPR	EEA	Reject	8	0.6%
		Success	117	9%
	IMG	Reject	26	2%
		Success	476	25%
	UK	Reject	15	1%
		Success	703	52%
Grand Total			**1345**	

App Type	Place of PMQ	Outcome	Total	Approx %
CESR	EEA	Reject	79	3%
		Success	60	2%
	IMG	Reject	885	35%
		Success	1252	48%
	UK	Reject	73	3%
		Success	211	8%
Grand Total			**2560**	

Age

CT General Practice

	Unknown	20-29	30-39	40-49	50-59	60-69	Grand Total
Years	Success	Success	Success	Success	Success	Success	
2005		96	171	22	2		291
2006	2	685	1032	178	17		1914
2007	4	789	1075	156	15	1	2040
2008	1	803	1026	103	5	2	1940
2009	1	604	1344	133	10		2092
2010	1	720	1393	113	7		2234
Grand Total	**9**	**3697**	**6041**	**705**	**56**	**3**	**10511**
Approx %	**0.08%**	**35%**	**57%**	**7%**	**0.5%**	**0.03%**	

CCT Specialty

	Unknown	20-29	30-39	40-49		50-59	60-69	Grand Total
Years	Success	Success	Success	Reject	Success	Success	Success	
2005	19		481	1	139	8		648
2006	49		2001		556	29	1	2636
2007	45		2236		608	33		2922
2008	22	3	2472		703	36		3236
2009	14	2	2571		721	33		3341
2010	12		2530		813	47		3402
Grand Total	**161**	**5**	**12291**	**1**	**3540**	**186**	**1**	**16185**
Approx %	1%	0.03%	76%	0.006%	22%	1%	0.006%	

CEGPR

	Unknown		20-29		30-39		40-49		50-59		60-69		Grand Total
Years	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success	
2005		3		8	2	46	3	25	2	4			93
2006		9		49	3	267	4	126	7	37	2	3	507
2007	1			36	2	212	1	59	1	12		1	325
2008		1		35	5	156	3	34	1	3			238
2009			1	12	4	81	1	21	2	4			126
2010		1		1	1	39		11	3				56
Grand Total	**1**	**14**	**1**	**141**	**17**	**801**	**12**	**276**	**16**	**60**	**2**	**4**	**1345**
Approx %	0.07%	1%	0.07%	10%	1%	60%	1%	21%	1%	4%	0.1%	0.2%	

CESR

	Unknown		20-29	30-39		40-49		50-59		60-69		70 – 79		Grand Total
Years	Reject	Success	Reject	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success	
2005	31	25	1	18	31	157	208	106	99	28	14	1		719
2006	25	24		42	70	141	168	90	99	13	6		1	679
2007	12	15		33	58	74	134	53	63	11	3			456
2008	1	9		17	70	43	85	19	30	7	4			285
2009	1	13		23	62	44	99	22	34	2	3			303
2010		2		5	23	8	50	9	21					118
Grand Total	**70**	**88**	**1**	**138**	**314**	**467**	**744**	**299**	**346**	**61**	**30**	**1**	**1**	**2560**
Approx %	3%	3%	0.03%	5%	12%	18%	29%	12%	13%	2%	1%	0.03%	0.03%	

Ethnicity

CCT GP

	2005	2006	2007	2008	2009	2010	Grand Total	Approx %
Ethnic Origin - Level 1	Success	Success	Success	Success	Success	Success		
Asian or Asian British	66	453	560	579	676	660	2994	28%
Black or Black British	7	58	54	43	86	55	303	3%
Mixed	7	18	23	37	35	53	173	2%
Not stated				1			1	0.009%
Other ethnic groups	9	42	37	44	62	71	265	2%
Unspecified	95	645	589	358	354	376	2417	22%
White	107	698	777	878	879	1019	4359	41%
Grand Total	**291**	**1914**	**2040**	**1940**	**2092**	**2234**	**10511**	

CCT Specialist

	2005		2006	2007	2008	2009	2010	Grand Total	Approx %
Ethnic Origin - Level 1	Reject	Success	Success	Success	Success	Success	Success		
Asian or Asian British		128	670	751	933	1012	1045	4539	28%
Black or Black British		19	67	88	106	100	100	480	3%
Mixed		12	41	43	55	57	65	273	2%
Not stated					1			1	0.006%
Other ethnic groups		25	123	161	164	169	169	811	5%
Unspecified		125	452	365	376	372	445	2136	13%
White	1	338	1283	1514	1601	1631	1578	7947	49%
Grand Total	**1**	**647**	**2636**	**2922**	**3236**	**3341**	**3402**	**16185**	

CEGPR

	2005		2006		2007		2008		2009		2010		Grand Total	Approx %
Ethnic Origin - Level 1	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success		
Asian or Asian British		27	4	104	1	68		47	5	22		14	292	22%
Black or Black British		1	1	25		6		4		2		1	40	3%
Mixed		1		8		4		2					15	1%
Other ethnic groups		2		16		10		10		3		2	43	3%
Unspecified	4	30	5	170	3	98	3	62	2	27	1	16	421	31%
White	3	25	6	168	1	134	6	104	1	64	3	19	534	40%
Grand Total	**7**	**86**	**16**	**491**	**5**	**320**	**9**	**229**	**8**	**118**	**4**	**52**	**1345**	

CESR

	2005		2006		2007		2008		2009		2010		Grand Total	Approx %
Ethnic Origin - Level 1	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success	Reject	Success		
Asian or Asian British	130	164	140	132	54	99	24	78	36	80	5	42	984	38%
Black or Black British	26	40	21	19	14	14	6	12	7	14	2	4	179	7%
Mixed	10	10	10	6	12	7	2	9	2	6	1	2	77	3%
Not stated									1				1	0.03%
Other ethnic groups	30	38	22	31	19	24	7	11	7	16	1	9	215	8%
Unspecified	102	66	63	97	50	60	29	39	20	50	8	18	602	24%
White	44	59	55	83	34	69	19	49	19	45	5	21	502	20%
Grand Total	**342**	**377**	**311**	**368**	**183**	**273**	**87**	**198**	**92**	**211**	**22**	**96**	**2560**	

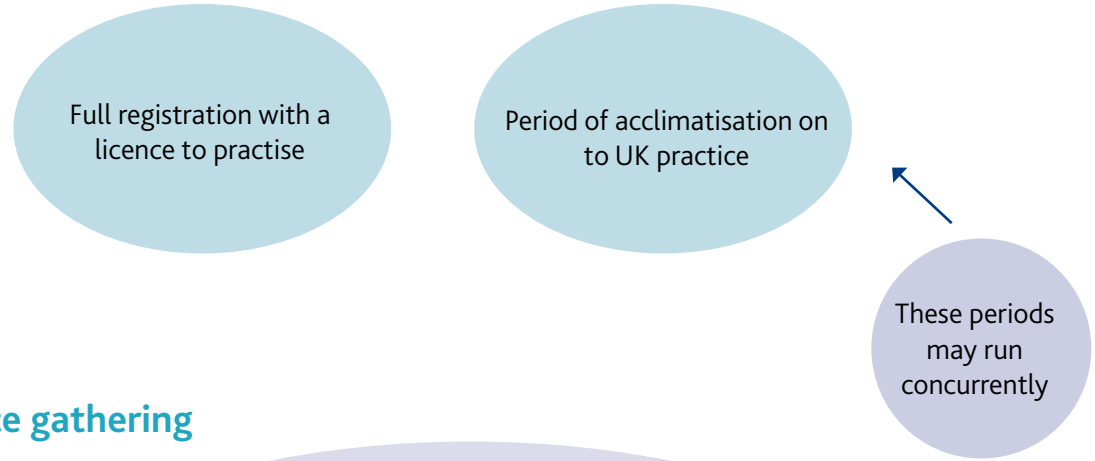
CEGPR and CESR success and failure percentages

CEGPR	Asian or Asian British		Black or Black British		Mixed		Not stated	Other Ethnic Groups		Unspecified		White		Grand Total
	Reject	Success	Reject	Success	Reject	Success	Reject	Reject	Success	Reject	Success	Reject	Success	
Total	**10**	**282**	**1**	**0**	**0**	**15**	**0**	**0**	**43**	**18**	**403**	**20**	**514**	**1345**
Approx %	**0.7%**	**21%**	**0.07%**	0%	0%	1%	0%	0%	3%	1%	30%	1%	38%	

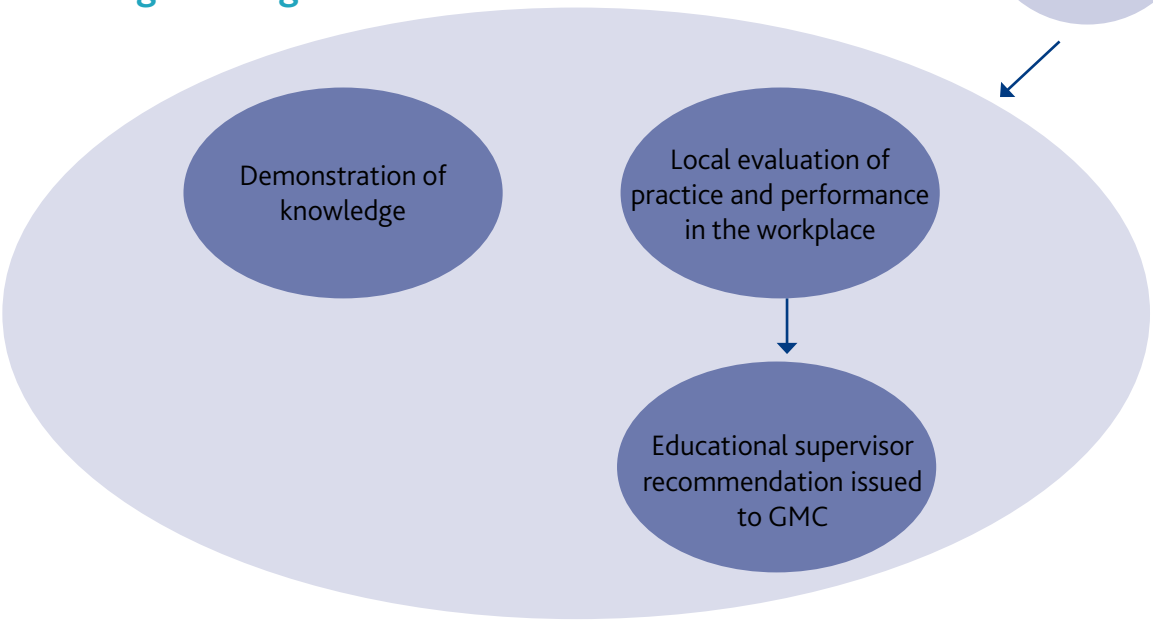
CESR	Asian or Asian British		Black or Black British		Mixed		Not stated	Other Ethnic Groups		Unspecified		White		Grand Total
	Reject	Success	Reject	Success	Reject	Success	Reject	Reject	Success	Reject	Success	Reject	Success	
Total	**389**	**595**	**76**	**103**	**37**	**40**	**1**	**86**	**129**	**272**	**330**	**176**	**326**	**2560**
Approx %	15%	23%	3%	4%	1%	1%	0.03%	3%	5%	11%	13%	7%	13%	

Appendix 6: A new model for evaluation

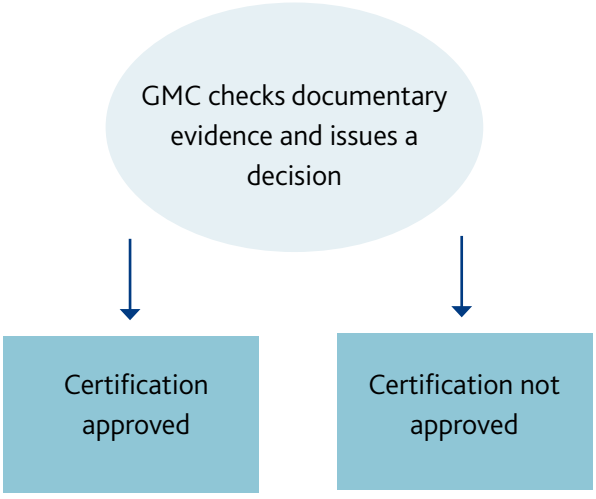
Entry criteria



Evidence gathering



Evaluation



Appendix 7: Eminent overseas doctors: eligibility criteria

- A recognised UK primary medical qualification or an overseas primary medical qualification acceptable to the GMC.
- A letter of personal recommendation from the President of the relevant UK medical royal college or faculty which explicitly attests to the applicant's international standing in their field. Where relevant, the medical royal college or Faculty recommending the applicant should consult with the appropriate specialist society.
- A letter of personal recommendation from the President of the equivalent body to a UK medical royal college in the state where the applicant works.
- Documentary evidence from the regulator in the state where the applicant works of their entitlement to practise as a specialist in the relevant field in that jurisdiction.
- Documentary evidence from the regulator in the state where the applicant works (and from any other jurisdiction where they have worked during the previous five years) of their good standing.
- Documentary evidence that the applicant holds (or has held within the previous 12 months) an academic or clinical post at the same level as the one they are proposing to take up in the UK and in the same or in a related field.
- Documentary evidence from the applicant's prospective UK employer that they have been offered a professorship or chair in a UK academic institution (or equivalent level post elsewhere, such as a post leading a major NHS service). Appointment to a UK consultant post should not, in itself, be sufficient.
- Documentary evidence from the prospective employer that the proposed post carries an associated NHS contract which legally requires GP or specialist registration or, in the absence of such a contract, an explanation of why GP or specialist registration is required.
- Evidence of the applicant's eminence in their field. This could include papers published in high profile peer reviewed journals, evidence of leading research in the field, clinical awards or appointments to senior positions. Such evidence would need to be validated.
- Evidence of English language proficiency as demonstrated by other international medical graduates.
- Independent evaluation of the application by a GMC specialist adviser who is eminent in the relevant, or a related, field.
- Applicants seeking to work in general practice must provide evidence of approval for their inclusion in the Performers List.

In view of the leadership roles such individuals would be undertaking, often with related honorary NHS consultant contracts, it is in the interests of patient safety for the GMC to seek assurance of their ability to practise at the level of an NHS consultant. To this end, the GMC should look for evidence of the sort of generic skills that would be expected of those appointed to consultant posts.

The GMC is considering developing generic outcomes for all speciality training. Eminent specialists should be asked to provide evidence of how they meet such outcomes. The generic outcomes work is still in its early stages, but the attributes for which the GMC might expect to see evidence include:

- General clinical skills – this includes management of the acutely ill patient and safe prescribing.
- Management – including budget management and clinical governance.
- Patient safety – this includes audit and understanding the importance of patient centred care.
- Leadership – including implementing change, service development and crisis leadership.
- Communication – team work, inter-professional communication and dealing with conflict.
- Personal behaviour – this includes professional conduct and probity as well as skills such as teaching and time management.
- Commitment to equality and diversity.

References

1 GMC, Final Report of the Education and Training Regulation Policy Review: Recommendations and Options for the Future Regulation of Education and Training, 18 March 2010.

2 This is a legal requirement which does not apply for doctors working in NHS Foundation Trusts in England, although in practice most Foundation Trusts do require doctors they are appointing to be on either the specialist register or the GP register.

3 Prior to 2005 more limited arrangements had been operated by the Specialist Training Authority of the medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP).

4 The Postgraduate Medical Education and Training Order of Council 2010, article 8.

5 Recognised specialties are specialties for which the curriculum and assessment systems have been approved by the GMC for UK training programmes.

6 Applying for CESR: Top Tips, GMC.

7 GMC Frequently Asked Questions – Certification of Eligibility for Specialist Registration (CESR) and Certificate of Eligibility for GP Registration (CEGPR).

8 The application fee for CESR and CEGPR applicants is £1500. The fee for doctors seeking a CESR(CP) or CEGPR(CP) is £390.

9 Working group minutes 24 March 2011; and Zircadian Consulting, Perceptions of the CESR/CEGPR Routes to Registration Research Project, p25.

10 Zircadian Consulting, Perceptions of the CESR/CEGPR Routes to Registration Research Project, p198-200.

11 Zircadian Consulting, Perceptions of the CESR/CEGPR Routes to Registration Research Project, p200-201.

12 The Zircadian research records the views of the profession as to why CESR/CEGPR doctors may find it more difficult to progress. Zircadian report, p198.

13 Around 1% across all applications.

14 Summary Note of Staff and Associate Specialist (SAS) Doctors Roundtable Meeting, GMC 12 May 2011. Zircadian Consulting, Perceptions of the CESR/CEGPR Routes to Registration Research Project, pp124-125.

15 Further information about recognition of CCTs, CESR and CEGPRs in Europe can be found on the GMC's website atwww.gmc-uk.org/doctors/before_you_apply/background.asp.

16 Inclusion in the specialist register is used as a requirement for securing research grants.

17 The high number of specialties listed in the register is not wholly attributable to the CESR process. Most are the result of the 'grandfathering' arrangements put in place when the specialist register was set up to allow doctors who were already in consultant posts at the time to have their details included in the register.

18 The number of recognised specialties is not fixed. At the time of preparing this report there were 61 recognised specialties, but several more were under consideration.

19 Summary Note of Staff and Associate Specialist (SAS) Doctors Roundtable Meeting, GMC 12 May 2011.

20 The Zircadian report acknowledges that there is 'some bias in the results according to awareness of certification routes. This is an expected finding and confirms the requirement to improve awareness of routes to certification amongst the profession.' p.200.

21 www.gmc-uk.org/about/research/research_commissioned_3.asp.

22 Whole-time equivalent.

23 GMC, Learning and assessment in the clinical environment: the way forward – November 2011.

24 GMC, Learning and assessment in the clinical environment: the way forward – November 2011.

25 GMC, Recognising and Approving Trainers: A Consultation. https://gmc.e-consultation.net/econsult/default.aspx.

26 Only doctors with a National Training Number are regarded by primary care organisations as being in GP training.

27 This happens in around 1% of cases.

28 Zircadian Consulting, Perceptions of the CESR/CEGPR Routes to Registration Research Project, p 199.

29 PMETB, Report on Subspecialty Training, March 2010.

30 Summary Note of Staff and Associate Specialist (SAS) Doctors Roundtable Meeting, GMC 12 May 2011.

31 Whole-time equivalent.

32 It is possible that an applicant will have qualified in the UK before pursuing their career overseas.

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Published February 2012

GMC/RGPS_C/0312

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