

**Culture, Tourism, Europe and External Affairs Committee**

**Inquiry - Article 50: Preparedness**

**Written submission from General Medical Council**

**Health select committee inquiry: Impact of a no deal Brexit on health and social care**

**Executive summary**

1. Leaving the EU could have a significant impact on the regulation, movement and education of doctors. The impact could be significant in all four UK countries, but (for different reasons) there are particular challenges potentially facing Scotland, Wales and Northern Ireland.
2. We are therefore concerned that with less than six months to go before EU exit and increasing talk of the possibility of a 'no deal' we still do not know how, and how quickly, EEA qualified doctors will be able to join the UK medical register.
3. It is essential that exiting the EU does not either deliberately or inadvertently deter the approximately 2,000 EEA qualified doctors who come here each year and contribute to the NHS. This submission summarises a number of issues that EU withdrawal, and the nature of it, will place on healthcare professional regulation and thus patient safety. We also summarise a number of the discussions we are holding with the UK and devolved governments.
4. As the UK medical regulator we are doing all that we can to prepare for the various scenarios that we may face in March 2019, while we await the outcome of the negotiations. These preparations are resource intensive and we running out of time to implement whichever route to the register the UK government decides to put in place for this important cohort of doctors. There is a risk that the continuing uncertainty will deter EEA doctors from coming to the UK and contributing to our NHS.
5. It is imperative that the UK government now provides clarity and certainty on the systems that we need to put in place for registering EEA qualified doctors.

**Introduction**

6. The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK.
  - We decide which doctors are qualified to work here and we oversee UK medical education and training
  - We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers
  - We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

7. While regulation of the medical profession is reserved to Westminster, the GMC operates within the legal and legislative structures of the different jurisdictions within the UK. As an example of this, our guidance for doctors reflects the laws of all Scotland, and when a law changes we seek senior counsel's advice on whether we would need to update our guidance.
8. Our statutory powers are set out in the Medical Act 1983. The way in which we regulate doctors from the European Economic Area (EEA) is determined by the mutual recognition of professional qualifications Directive (2005/36/EC), which is transposed into UK law via the 1983 Act.
9. In Scotland, over 1,250 doctors from the EEA are currently registered with the GMC to practise medicine in the UK (over 30,000 doctors UK-wide), with over 1,150 of these holding a license to practise (over 21,700 UK-wide). Our health service benefits considerably from the contribution of overseas doctors and this has not changed because of the vote to leave the EU.

### **The EEA medical workforce in the UK**

10. Doctors from Europe make a vital contribution to the health services across the UK. 9% of all licensed doctors in 2018 were EEA graduates (5.8% for Scotland). That's approximately 21,700 doctors (over 1,150 for Scotland). Our data shows that this number has remained fairly constant over the last three years.
11. Our latest data report<sup>1</sup> shows that, UK-wide, 14% of the specialist register were EEA graduates with certain specialties such as ophthalmology (24%) and surgery (18%) being more reliant on this group. In Scotland, 9% of the specialist register are EEA graduates, with anaesthetics and intensive care medicine (15%), pathology (13%) and surgery (13%) being more reliant on this group.
12. When the four countries of the UK are compared, Northern Ireland has the largest percentage of its workforce holding an EEA Primary Medical Qualification (PMQ), with 71% of those graduating in the Republic of Ireland.
13. For the first time, 2018 saw the number of graduates from Central Europe, Eastern Europe and Baltic countries exceed those from North-western Europe. But, as in 2017, over half of all EEAs graduated from just four countries: Ireland, Greece, Italy and Germany.

### *Differences between the four countries of the UK*

14. Brexit will instigate significant questions for workforce arrangements in all four countries of the UK, especially in Northern Ireland which is the only part of the UK that shares a land border with another EU country. This is compounded by the development of more cross border working in recent years and the integration of some medical services on the island of Ireland.

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<sup>1</sup> <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/our-data-about-doctors-with-a-european-primary-medical-qualification-in-2018>

15. Our data shows that there are a similar proportion of EEA graduates in each broad area of practice in Scotland and Wales. Northern Ireland has the greatest proportion of EEA graduates who are GPs. England has the most EEA graduates who are specialists or on neither register and not in training.
16. In Northern Ireland, 9.9% (170) of GPs are EEA graduates with 86.5% (147) of those having qualified in Ireland. Scotland, Wales and England have relatively low reliance on EEA GPs with 3.7% to 4.9% of their GPs qualified in the EEA.
17. However these figures do not reflect the relative high dependency on EEA qualified doctors in certain areas of the UK. We know that in some remote and rural areas in Scotland and Wales, there are a higher percentage of non-UK licensed doctors than the overall UK figure.
18. In Scotland this includes Argyll and Bute, the Western Isles, Orkney, and Shetland.
19. In Wales, Hywel Dda University Health Board covering west Wales has the highest percentage of doctors with an EEA primary medical qualification of all Welsh health boards, standing at 10.6% of its 887 connected doctors.
20. Additionally, Betsi Cadwaladr UHB covering north Wales has the second highest dependency on doctors with an EEA primary medical qualification, standing at 9.3% of its 1,476 connected doctors.

### **Impact of 'no deal' Brexit on medical regulation**

21. In the event that the UK Government and EU leaders are unable to reach agreement on the terms of the UK's withdrawal from the EU, we foresee three possible scenarios for medical regulation post-March 2019.

**Option 1 Applications for registration from EEA qualified doctors are considered via the existing routes for International Medical Graduates (IMGs).** This means that they may be required to sit the Professional and Linguistic Assessment Board (PLAB) exams before being granted registration and, for specialist or GP registration may have to demonstrate documented equivalence to a curriculum that covers specialist training and experience in the UK. These are called the Certificate of Eligibility for Specialist Registration (CESR) and Certificate of Eligibility for GP Registration (CEGPR) processes – sometimes referred to as the equivalence routes.

**Option 2 The UK government invites the UK Parliament to unilaterally maintain the current system of automatic recognition granted by virtue of the mutual recognition of professional qualifications (MRPQ) Directive – but for a time limited period.** This would allow EEA qualified doctors to have automatic access to the UK medical register as they do now. However the implications of continuing with a system of preferential treatment for EEA doctors, despite the UK no longer being part of the EU, would need to be very carefully considered.

**Option 3 A bespoke framework is created for EEA qualified doctors** which would straddle the above two options to limit the impact of a 'no deal' Brexit, whether in the short-term only or for the foreseeable future.

22. We would not support any option or policy position that would either deliberately or inadvertently deter the approximately 2,000 EEA qualified doctors who come to the UK each year and contribute to the NHS.
23. In our view, the best option is option 2 above - a legally codified and prescriptive framework which mirrors our obligations under the current MRPQ Directive, but for a time-limited period only, to mitigate the short-term workforce risks and provide a breathing space for the development in the long-term of a new, more robust but more flexible regime to register doctors regardless of where they qualified outside of the UK. Under this we would be mandated to continue to automatically recognise EEA qualifications. The strict legal basis would avoid the risk of challenge on the grounds of equality and discrimination.
24. However it is essential that this framework is strictly time limited to enable us to work with the UK Government in collaboration with the devolved governments to design a new registration system that supports our long term vision for the UK, and Scotland, to be an attractive place for all doctors who qualified outside the UK and that our requirements for entry to the medical register should be simplified. This system needs to be fair for all doctors joining the medical registers, regardless of where in the world they qualified. This would set a clear threshold for medical practice in the UK and would ensure patient safety in the post-Brexit healthcare environment.

### **The hard Brexit scenarios**

25. There are advantages and disadvantages to all of the above options. What is clear to us is that, with less than six month before a possible 'no deal' Brexit, we are now limited as to the viability of certain options. We would not support any option or policy position that would either deliberately or inadvertently deter the approximately 2,000 EEA qualified doctors who come here each year and contribute to the NHS.
26. In terms of planning and preparedness, the first two options which provide a clear cut and pre-exiting route to registration would be easier to implement by March 2019. However they are not without risks.

### **Option 1: EEA doctors treated as IMGs from EU exit day**

27. It is difficult to predict what impact this approach would have on the flow of EEA doctors but given how different it is from the current system of automatic recognition it is likely to substantially diminish the attractiveness of the UK for EEA qualified doctors in the short to medium term and result in smaller numbers applying. The impact on the NHS in Scotland could be significant and immediate.
28. It also presents us with some significant logistical challenges. Moving approximately 2,000 EEA qualified applicants per year to the IMG registration process for basic medical registration would require significant additional capacity within the GMC Clinical Assessment Centre (CAC) to handle the additional PLAB assessments, and from 2022 onwards, the Clinical Professional Standards Assessment component of the Medical Licensing Assessment.

29. In addition the equivalence routes that we apply for IMG doctors wishing to join the specialist and GP registers are set out in very prescriptive secondary legislation<sup>2</sup>. We have called on the UK government to reform these routes for some time and an increase in the numbers following these routes would pose an increased burden on EEA doctors, the GMC, and the Royal Colleges whose expertise we need to help us to assess each application. Importantly it can also result in a delay of around 18 months between initial application and acceptance onto the register. There is a global market for doctors who are in short supply in many countries both in the developed and developing worlds. Making the process for obtaining registration in the UK more difficult involves a significant risk for the NHS.

### **Option 2: Keeping MRPQ – but for a time limited period**

30. Under European law, doctors who are nationals of the EEA (and those who are entitled to count as such) and hold medical qualifications from another country in the EEA are entitled to have their qualifications recognised and to pursue the medical profession in the UK with the same rights as doctors who qualified in the UK. This entitlement is set on the basis of their qualification meeting the minimum training requirements outlined in the Directive and which are set out solely in terms of time spent in training. We have long argued that time spent in training alone does not provide us with the necessary evidence to assure us that European qualifications awarded outside of the UK are indeed equivalent to the experience and skills we require of medical practice professionals that have qualified in the UK.
31. Brexit provides us with an opportunity, in the medium to long term, to reform the registration requirements for all doctors wishing to practise in the UK and in line with our Council's decision that registration post-Brexit should adhere to the following principles:
- a) Unless legislation requires us to take a particular course of action, any choices we make within what is permitted by law must be evidence based.
  - b) Any action we take must prioritise public protection over any other consideration. Although we have a strong interest in promoting workforce mobility and expansion, this cannot be to the detriment of patient safety.
  - c) Any action we take, unless prescribed by legislation, must ensure equitable treatment between cohorts where appropriate – in compliance with equality legislation.
  - d) Any action we take should be in keeping with our push for a more flexible regulatory framework and the discretion to develop (within broad parameters) new approaches for granting access to the medical register and for recognising and approving medical education and training.
32. Retaining the key provisions of the MRPQ Directive in UK law for a time limited period would maintain the automatic ability of EEA qualified doctors to join the UK register and is the option most likely to minimise the impact of a 'no deal' Brexit on the flow of incoming professionals and any ensuring risks associated with workforce shortages.

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<sup>2</sup> Postgraduate Medical Education Training Order 2010 (amended 2012) and Applications for General Practice and Specialist Registration Regulations 2010 (amended 2011)

33. However, we must highlight that even with a unilateral application of MRPQ, there would remain a risk of a delay in the flow of EEA medical professionals to the UK. This is because the requirements for information sharing set out in the Directive are unlikely to be reciprocated by the 27 other EU member states and our exclusion from the European Commission's Internal Market Information (IMI) system would make it difficult for us to obtain the necessary documents and confirmations from European competent authorities that enable us to grant automatic recognition in a prompt way. Wider considerations (such as economic and the immigration and visa regime) will also play a role.
34. Some may also argue that this option, even if only in place for a limited period, does not reflect the outcome of the 2016 referendum.
35. That said, on balance, we believe that the maintenance of the regime for a time limited period would ensure that the medical workforce in the UK is least affected by a 'no deal' Brexit. It would also provide us with the unique opportunity to consider the wholesale reform to our registration processes that we have long been calling for as part of the wider reform to professional regulation (which has long enjoyed cross-party support both at a UK-wide level and in Scotland).
36. Due to lack of parliamentary time at Westminster we would not be able to deliver wholesale reform by March 2019 but are committed to work with the UK government in collaboration with the devolved governments to make this happen before the end of the time limited period.
37. Wholesale reform to our registration system would also be in line with the Migration Advisory Committee recommendation that the UK should move to a system in which all migration is managed with no preferential access given to EU citizens.

### **Option 3: A bespoke framework for EEA doctors for the short-term or for the foreseeable future**

38. It may be possible to devise a bespoke approach for EEA doctors under which they would enjoy certain privileges not extended to IMGs. However, any framework which granted some form of preferential, discretionary treatment to EEA applicants over international applicants without sufficient justification in policy terms and a clear basis in UK law would risk leaving us open to legal challenge.
39. We would also struggle to implement and operationalise a new bespoke system in such a short period of time. Registration systems are complex – underpinned by substantial IT systems and dependent on a supporting policy, legal, operational and communications infrastructure, they take time and careful consideration to develop. This option is probably not deliverable in the short-term and much less attractive in the long-term than wholesale reform (option 2).

### **GMC preparedness for 'no deal' Brexit**

40. We have considered how, in the light of this uncertainty, we should move forward in terms of our planning for how best to regulate the medical profession as the UK leaves the EU.

## Workforce capacity planning

41. As outlined above, we do not yet know the impact of a 'no deal' Brexit on the registration of EEA qualified doctors, and therefore on the NHS. We have undertaken some modelling based on the assumption that we would be legally required to treat applications received from a doctor who qualified within the EEA as an IMG. This would have an important operational impact and, as a responsible regulator, we are making contingency plans so that we can meet this challenge should it materialise in March 2019.
42. In recent years around 1,300 EEA qualified doctors each year have joined the specialist and GP registers via automatic recognition of their EEA qualification, falling to 1,100 in the last year for which we have data. To provide context, we know that of the 1,375 EEA graduates that joined our registers in 2016 via automatic recognition of their professional qualifications, we can identify that 55 (4%) were located in Scotland in 2017. This is broadly in line with the proportion of all EEA doctors who work in Scotland (5%). In 2017, 1,110 EEA graduates joined the UK's GP and specialist registers via automatic recognition of their qualification. We know that around 5% of all of the UK's EEA graduates with a license to practise in 2017 worked in Scotland. If the RPQ Directive ceased to apply to the UK after EU exit, all of these doctors would have to follow the 'equivalence' route onto our register. Set out in secondary legislation, this is an exhaustive and bureaucratic process which places pressures on both applicants and on the Royal Colleges who work with us to process the applications. Importantly it can also result in a delay of around 18 months between initial application and acceptance onto the register. This is highly likely to impact on professional mobility and workforce planning.

## Clinical assessment capacity planning

43. One of the principal routes for IMG doctors to access the basic medical register is the Professional and Linguistic Assessments Board test (PLAB). Part 2 of PLAB – the assessment of clinical skills - takes place in our Clinical Assessment Centre in Manchester which is already running at full capacity. We are currently exploring the options to source additional capacity elsewhere. This is now even more urgent as we make preparations for a 'no deal' Brexit and the potential need to further increase capacity to allow for EEA graduates to sit the PLAB test after March 2019.
44. To be sure of having access to additional capacity we need to both find and resource it – bespoke clinical assessment centres are relatively rare, costly to run and maintain.
45. In addition, we would need to work with the British Council who currently runs the assessment for Part 1 of the PLAB exam. There are currently no assessments run in the EU 27 member states. We would require time to engage with the British Council to establish capacity to do this.
46. In order to explore how we can better support international doctors seeking to register with the GMC and work in Scotland, we are currently running a pilot to hold Part 1 of the PLAB exam in our Edinburgh office. With all places taken for our first exam in September and places for the second exam in November having all been allocated, we are pleased to be continuing this into 2019.

## Business process changes

47. The business processes and the supporting Information System (IS) infrastructure which enable us to register doctors (whether UK, EEA or IMG) are extremely complex, and making changes to them is both time-consuming and costly. We are at the point of no return in relation to reconfiguring those systems and processes in time for March 2019, should the Withdrawal Agreement not be finalised.
48. Accordingly, we will shortly begin to incur potentially significant costs in making contingency plans to treat EEA doctors as IMGs from 30 March 2019, unless we receive an explicit and legally valid assurance that the earliest such changes might be needed is after a transition period.
49. We do not take lightly any decision that involves spending the money that our registrants pay to us. At the same time, we cannot take the risk that our systems will not be able to cope with a 'no deal' outcome which would require us to treat EEA doctors as IMGs in less than six months' time. We would need to report and justify any such expenditure in our annual report to the UK Parliament.

## Conclusion

50. As we outlined earlier in the year in our evidence to the Health and Sport Committee's inquiry into the impact of leaving the EU on health and social care in Scotland<sup>3</sup>, leaving the EU could have a significant impact on the regulation, movement and education of doctors. The impact could be significant in all four UK countries, but (for different reasons) there are particular challenges potentially facing Scotland, Wales and Northern Ireland.
51. Our submission was consistent with our 2016 submission to the Westminster Health Select Committee Inquiry on the impact of Brexit on health and social care<sup>4</sup>. Two years on from our submission to the committee, we still do not have confirmation from the UK Government on how they would like us to deal with applications from doctors who currently have an automatic recognition right under the 2005/36/EC Directive in the case of a 'no deal' Brexit. This has impacted on our ability to plan for a potential 'no deal' scenario.
52. A 'no deal' Brexit in March 2019 would pose challenges for the GMC in registering doctors and therefore have an impact on the NHS. We must ensure that we continue to meet our statutory, regulatory functions whilst also working to ensure that the medical workforce is not destabilised and patient safety is maintained.
53. We must also ensure that any option or policy position does not either deliberately or inadvertently deter the EEA qualified doctors who come here each year and contribute to the NHS.

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<sup>3</sup> [www.parliament.scot/S5\\_HealthandSportCommittee/Inquiries/BREX015\\_GMC.pdf](http://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/BREX015_GMC.pdf)

<sup>4</sup> <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/brexit-and-health-and-social-care/oral/48236.html>

54. We also want to work with the UK government in collaboration with the devolved governments to maintain the supply of medical professionals to the UK from elsewhere in the world to ensure safe and effective care can continue to be provided in the future.
55. The lack of clarity over what registration system will be put in place for EEA qualified doctors is deeply worrying – we have certainly passed the point of no return for designing and implementing a new, bespoke system by March 2019.
56. We have long argued that the legislation that covers our registration responsibilities is increasingly outdated, and far too prescriptive about what applicants have to do. Despite being amended from time to time over the years, it hasn't kept pace at a fundamental level with changing demand in the UK health services. We would like new legislation that would allow us more flexibility, and have been pressing for that for some time.
57. In light of this, we see the best option for the short term to be a legally codified and prescriptive framework which mirrors the current MRPQ Directive, as set above (option 2). Under this we would be mandated to continue to automatically recognise EEA qualifications. The strict legal basis would avoid the risk of challenge on the grounds of equality and discrimination.
58. However it is essential that this framework is strictly time limited to enable us to work with the UK Government in collaboration with devolved governments to design a new registration system that is fair for all doctors joining the medical registers, regardless of where in the world they qualified. This would set a clear threshold for medical practice in the UK and would ensure patient safety in the post-Brexit healthcare environment.