

Policy Analysis

The Accreditation and Quality Processes of the General Medical Council (United Kingdom)

Lee Harvey

Director of the Centre for Research and Evaluation
Sheffield Hallam University

The British accreditation context

In the UK, most of the professions are controlled to a greater or lesser extent by a professional or regulatory body. In most cases, these bodies, and there are more than 100 of them, have some input into professional education. However, the degree to which control is exercised over the profession and over the training of professionals varies enormously from one body to another.

Accreditation of programmes in the UK provides approval and recognition of academic and vocational awards. Accreditation is vital if a higher education institution wishes to run courses that offer awards controlled by professional or regulatory bodies. The approach and extent of accreditation varies from the recognition of courses as representing industry standards of training (such as those accredited by the National Council for the Training of Broadcast Journalists) to the complex and tightly constrained legally-binding procedures of the General Medical Council.

There is a considerable difference between voluntary regulation by a professional body and by a regulatory body. The former is regulation by a body representing, in the last resort, the interests of the professionals. The latter is regulation by a non-membership body, established by law to protect the public. The General Medical Council is such a body.

Regulatory body

A regulatory body is created by government to regulate qualifications or training for a particular occupation. Unlike professional bodies, regulatory bodies do not offer membership to practitioners and do not see themselves as serving practitioners in the first instance. The Teacher Training Agency, for example, claimed, when it was established that it served:

the educational community generally. Specifically we serve the Secretary of State as agents of the Education Act within the remit we were given in that Act... and we serve the colleges and schools that are involved with teacher training. (TTA, 1995)

Regulatory bodies exercise control over the profession in various ways. They are external watchdogs at one step removed from the profession. Regulatory bodies usually:

- control entry to the profession by specifying the required knowledge and competence;
- maintain a register of practitioners, inclusion on which is required for continued practice;
- enforce a code of practice determined to be in the public interest.

Most, but not all, regulatory bodies are established by statute and have their powers defined by statute. However, not all UK regulatory bodies maintain a register of practitioners. However, the regulatory bodies in the areas of medicine and health do have statutory powers and maintain a register of practitioners. These include the:

- General Medical Council
- General Dental Council
- Health Professions Council
- Nursing and Midwifery Council
- The General Osteopathic Council

Health and medicine are, thus, regulated by separate bodies in the UK.¹

Role of the General Medical Council

The General Medical Council (GMC) is a regulatory body established under the *Medical Act* of 1858. Its by-line is 'Protecting patients, guiding doctors'. The GMC is formally established as a registered charity with strong and effective legal powers under the Act, designed to maintain the standards the public have a right to expect of doctors.

The governing body, the Council, has 35 members (19 doctors elected by the doctors on the register, 14 members of the public appointed by the Privy Council and 2 academics appointed by the universities and medical royal colleges). The GMC regulates the medical profession in its entirety: it

¹ Within the health area there are other regulatory bodies but they have no statutory powers and registration with these bodies is not required in order to practice but they do have a role in health-related education

accredits educational provision and registers practitioners. Without accreditation, the education is effectively valueless as it will not lead to registration. Without registration a qualified medic cannot practice.

Formation²

The GMC was formed as a result of the 1858 Medical Act. The Act was passed after eighteen years of Parliamentary debate on the reform of the medical profession. The debate mainly centred on the abolition, or at least the restriction of, unqualified practice. Seventeen previous Medical Bills had been introduced to Parliament between 1840 and 1858. Each of these had encountered problems because of conflicting interests and views.

The idea behind the 1858 Act was that anyone needing medical treatment should be able to distinguish between qualified and unqualified practitioners, which, at that time, was not always the case. There were 19 separate licensing bodies that conferred professional titles. The tests that doctors were expected to pass differed widely in nature. The various bodies used cheaper licences and easier exams to attract candidates. To help to counteract these problems, The Medical Act of 1858 authorised the establishment of the GMC and the publication of the Medical Register.

The GMC began to take responsibility for medical education 28 years later as a result of provision in the Medical Act of 1886. Following the 1886 Act, applicants for registration had to pass a qualifying examination. These examinations were administered by any licensing body or university authorised to grant medical qualifications. It became the GMC's responsibility to oversee the standard of the institutions and the examinations they offered. The GMC's role was to make sure that the standards were 'sufficient' to guarantee the knowledge and skills needed for efficient practice. If it appeared that any examination was 'insufficient', the General Council was bound to inform the Privy Council. They could, if necessary, order that the examination should no longer be deemed a qualifying examination.

GMC's responsibilities for medical education

The GMC's current responsibilities are an extension of those established in 1886. Its current responsibilities for medical education are set out in the Medical Act 1983, which it fulfils via a statutory Education Committee. The statutory duties of the GMC include the following:

- a. To determine the extent of the knowledge and skill required for the granting of primary medical degrees in the UK.
- b. To ensure that the universities provide medical undergraduates with the teaching and learning opportunities necessary to acquire that knowledge and skill.
- c. To determine the standard of proficiency required of the graduating medical student.

² Many thanks are due to Joanne Lowe, Registration and Education Directorate, General Medical Council, for providing me with the detail in this section through e-mail correspondence.

- d. To ensure that the examining bodies maintain this standard at qualifying examinations/assessments.
- e. To determine the patterns of experience that must be undertaken by trainees during the Pre-Registration House Officers (PRHO) year [internship year].
- f. To specify the form of the certificate to be completed by universities confirming that the required experience has been gained by trainees during the PRHO year.

According to the Act, ‘The Education Committee shall have the general function of promoting high standards of medical education and co-ordinating all stages of medical education.’ The Committee has specific responsibilities for undergraduate medical education delivered in the medical schools and for the first year of practice after graduation (the ‘PRHO year’). The GMC sets the outcomes that students and PRHOs must achieve and it quality assures the medical schools and the providers of PRHO training to ensure the outcomes are achieved. As such, the Education Committee of the GMC has ‘the power to visit universities to make sure that undergraduate teaching is appropriate and to inspect examinations to make sure that the standards expected at qualifying examinations are maintained and improved’ (GMC, 2005a). The GMC, on the basis of the work of the Education Committee, is statutorily obliged to make recommendations to the Privy Council about whether a university should be added to or removed from the list of institutions that can award a registerable UK medical degree (Sections 8 and 9 of the Act).

Just over 1% of the GMC’s total budget of £60m (2003–4) is spent under the heading ‘education’. In 2003–4, education expenditure mounted to £807,000 of which £384,000 was staffing cost, the remainder being mainly IT and other support and accommodation costs. It is not clear from the accounts whether Education is the only category that applies to the work of the Education Committee (or whether it is directly linked to the Committee at all) and whether the categories ‘standards’ (£836,000) and ‘revalidation’ (£692,000) also contribute to the costs of the education accreditation, also what proportion (if any) of management and administration (£4,949,000) might be added to the education costs. The 2003–4 budget for education represented an above-inflation increase on the previous year mainly due to an increase in costs of the visiting teams for the new quality assurance programme for basic medical education (discussed below).

The GMC is responsible for registering medical graduates who are able to work as doctors in the UK. Without registration, a person cannot practice medicine. The education of doctors is a continuous process. It starts formally at medical school where courses normally last five years (four for graduate entrants). It continues through initial training as a new doctor with limited responsibilities. (This is the year most doctors spend as pre-registration house officers). Next comes initial training as a fully-fledged doctor followed by training in the particular specialty chosen by the doctor. Throughout their careers, in addition to, and following on from their formal training, doctors keep themselves up-to-date through continuous professional development.

Control of medical education

In essence, the GMC not only accredits but controls medical education in the UK. If a school is not accredited, the qualification is effectively useless in the UK. For example:

Medical College London (MCL), although based in the United Kingdom, is not able to award UK primary qualifications leading to registration with the General Medical Council

because MCL is not listed in the Medical Act 1983. It is not a university in the European Union offering a primary European qualification recognised in the Medical Act. Its degrees will not lead to automatic registration with us. (GMC, 2004)

New schools

The only way new undergraduate medical programmes can be established is by the establishment of new medical schools. This requires the approval of the Privy Council, in the last resort, which will only be granted on receipt of a petition from the GMC, something it has, until recently, not done for decades.

The Education Committee (which is ultimately responsible to the Privy Council) has power to petition the Privy Council to add to the list of universities entitled to award registerable primary degrees in medicine and surgery in the event that new medical schools are established. The Committee would only proceed in this way if it were satisfied that the arrangements for teaching/learning and assessment met the requirements laid down in its *Recommendations on Undergraduate Medical Education*. It would satisfy itself by means of appointing a team to carry out a formal 'visit' (to assess the teaching) and 'inspection' (of the examinations/ assessments) over a five-year period, and would only reach a final decision when the first cohort of students had completed the five-year course and the qualifying examinations. (GMC, 1995)

Recently, GMC announced 'an exciting project to establish four new medical schools in the United Kingdom'. The new schools are Brighton Sussex Medical School, Hull York Medical School, Peninsula Medical School (Exeter and Plymouth), University of East Anglia Medical School. Taking this forward the GMC are required to make sure that the graduates from these medical schools can demonstrate the requirements set out in *Tomorrow's Doctors*.

To do this we are working with the four medical schools in a process that is similar to, but more intensive than, that proposed for the quality assurance of existing medical schools. Our aim is to recommend to the Privy Council that the graduates from these medical schools are given medical qualifications that allow them to be registered. (GMC, 2004)

GMC's responsibility for registration and licensure

The other way in which the GMC exercises ongoing control over the profession is via registration of doctors. Without registration doctors cannot practice medicine. The system of registration through which the General Medical Council (GMC) regulates doctors is about to change. This change will be enshrined in amendments to the Medical Act. The change attempts to link re-registration more firmly to continuing professional development and performance appraisal.

From 1 April 2005 every doctor wishing to practise medicine in the UK will need not only to be registered; but also to hold a licence to practise. The privileges currently conferred by law on doctors registered with the GMC will from 1 April 2005 be restricted to those holding a licence to practise.... Doctors will be required to satisfy the GMC, on a regular basis, that they are up to date and fit to practise. They will do this using evidence derived from their medical practice. This process, known as revalidation, will be a condition of a doctor's continued licensure with the GMC. (GMC, 2004b)

This is a central element of the reform process, which the GMC describe as ‘the most ambitious since the GMC was set up in 1858’, (GMC, 2004d). The process began with publication of *Good Medical Practice* (GMC, 1995), which ‘signalled a different approach to medical regulation’ (GMC, 2004d)

Instead of describing what doctors should not do, it sets out the principles that they should operate by and the standards of medical practice that every patient has a right to expect. This concept of regulation by the medical profession in partnership with the public is at the heart of all the changes now taking place – from the reform of our governance, which led to the establishment of the new Council in 2003, to the reforms of our Fitness to Practice procedures and new arrangements to revalidate the license to practise from 2005. Reform of governance marks a fundamental change in how we approach medical regulation, and has implications for everyone using medical services in the UK. (GMC, 2004d)

The intention is that all licensed doctors will face revalidation after five years (the initial revalidation from the start of the new process in 2005 will be staggered thereafter it will be a quinquennial review). The purpose of revalidation is to ensure that patients can have confidence that their doctors are competent and abide by high ethical standards. The proposals clearly reveal the patient focus of the GMC and of government policy and the degree to which the GMC controls the medical profession. This, as will be shown, lies at the heart of the educational accreditation process.

The revalidation process requires doctors to gather and present evidence drawn from medical practice, throughout the five-year period to show that they have been practising in accordance with the standards of competence, care and conduct set out in *Good Medical Practice*. The initial thoughts were that every doctor, regardless of specialty or type of practice, must:

- a. Keep a folder of information, drawn from his or her medical practice over the revalidation period.
- b. Reflect regularly on his or her standards of medical practice.
- c. Satisfy the GMC that there are no significant unresolved local concerns about his or her fitness to practise.(GMC, 2004b)

The exact nature of this process is yet to be implemented as it was put on hold following the Shipman Inquiry’s³ fifth report. The Department of Health issued a statement, in the wake of the fifth report, which included the decision to review the GMC’s proposed new system of revalidation. This has led to a last minute postponement of the intended launch of licensing and revalidation from April 2005. Given little alternative, the GMC have ‘warmly welcomed the review’. They note (GMC 2004):

The whole purpose of revalidation is to create public confidence that all licensed doctors are up to date and fit to practise, and if there are ways of improving the revalidation model we have proposed, we would of course want to include them in our plans.

As part of his review following the fifth Shipman report, Sir Liam Donaldson issued a ‘Call for Ideas’ to which the GMC published *Developing Medical Regulation: A Vision For The Future* in April

³ Dr Harold Shipman was a mass murderer who killed unknown numbers of patients. Despite a higher than average death rate amongst his patients, it took many years before he was apprehended. He subsequently apparently committed suicide while in custody before being brought to trial.

2005. The GMC view emphasises the need to: connect the different parts of the regulatory environment, ensure patients and public are involved, make information about registration accessible and meaningful to patients, doctors and employers, adopt a risk-based approach to regulation and distinguish resolving complaints from decisions about fitness to practice.

Funding

The majority of the GMC income comes from fees paid by registered doctors. The annual retention fee is currently £290 (subject to a discount for low income earners). The GMC had an annual income of £60million in 2003–4, of which annual retention fees accounted for £45million and another £6.5m came from initial registration fees of various sorts. Investment income amounted to only £1.5 million and publications for just £140,000. Most of the expenditure (57%) arose from assessing fitness for practice. The costs of registration (15%) and management and administration (10%) accounted for most of the remaining expenditure. The Professional and Linguistic Assessment Board (PLAB) Test, which is designed to test the ability of international medical graduates to work safely in a first appointment as a senior house officer in a UK hospital in the National Health Service (NHS), brings in £4.7 million but most of this (£4m) goes on expenditure, accounting for 8% of expenditure overall. There is no state subsidy despite being a body established by law.

Recent statements by the Secretary of State for health, John Reid (Dyer, 2005), reiterate the by-line of the GMC: ‘We want to put an end to the idea that the GMC is a representative body for doctors. It is not. Its primary role must be to protect patients.’ This has led for renewed calls for a review of the funding of the council. For example, a letter in the *British Medical Journal* headed: ‘Funding for GMC should come from taxpayers’, states that if the GMC does not purport to represent doctors, its costs should not be borne by the doctors but by the taxpayer. A licensing and registration body may be legitimately funded by doctors, but it is unreasonable to expect doctors to fund the extremely high costs of protecting patients from possible criminal elements. An organisation whose primary function is to protect patients and citizens should be funded in the same way as the police and report its findings to the courts and the licensing body. (Penney, 2005)

Political pressures and policy initiatives

The GMC, as a regulatory body, wields a double-edged sword: as accreditor of education and as licence granters to individual practitioners: the latter are to be subject to quinquennial review and strong sanctions. The development of the quality assurance process in both strands has been conditioned by the political agenda, which has shaped aspects of public policy.

The ‘better regulation’ and the ‘choice’ agendas, strongly advocated by the government (and which any likely opposition would also perpetuate should they gain power), are supposedly designed to give patients more say. As a result, the GMC has had to sharpen up a system of control and accreditation that has been, hitherto, rather taken for granted.

On the one hand, there is a need for more medics, recognised by expansion in the system and the need to delegate aspects of that expansion, in part, to the providers. There is an implicit

trust agenda that the GMC appears to want to develop. On the other hand, there is the consumer choice perspective, which applauds demystification of the profession, getting the ‘customer’ more involved in decision making and providing alternatives, while, in the area of medicine, in particular, ensuring client (patient) safety.

This is a situation that has been thrown into stark relief by exceptional circumstances (the Shipman affair, and more recently the case of Sir Roy Meadow⁴) and the scandal of ‘dirty’ hospitals and ‘superbugs’ that blight patient care. The background to the GMC reforms has been performance indicators, league tables, ‘naming and shaming’ and a continuous political battle over who can best provide for the nation’s health. During 2003–4, the GMC was embroiled in two other public inquiries⁵, apart from that of Shipman. The second phase of the Shipman Inquiry, chaired by High Court judge Dame Janet Smith, included an examination of monitoring and disciplinary and regulatory procedures and the handling of complaints. It turned the spotlight on the GMC’s past and current procedures and the reforms now being planned. In giving evidence, the GMC explained the thinking behind the reform programme, which has been approved by Government and Parliament, and described its proposals for a gateway that would make it less confusing for members of the public to register concerns or complaints about any aspect of the profession. The intention of the reform programme is to address ‘justifiable concerns’. In particular, the new procedures for revalidating doctors and investigating complaints energetically and effectively should ‘inspire public confidence in the profession’ (GMC, 2004d, p. 6).

However, the GMC faces sceptical criticism from the government’s *Better Regulation Task Force* (BRTF, 2004), which has a view on the National Health Service in general and general practitioners in particular. The NHS Plan, which is designed to ensure lines of accountability are strengthened and made more transparent, acknowledges that the regulation of the clinical professions needs to be strengthened, and that as a minimum self-regulatory bodies must change so that they:

- are smaller with much greater patient and public representation in their membership;
- have far more transparent procedures;
- develop meaningful accountability to the public and the health service. (BRTF, 2004)

The Task Force goes on to say that:

... Government and Parliament will have to judge whether the reforms proposed by the GMC, on which it is now consulting, will indeed protect patients and restore public and professional confidence. (BRTF, 2004)

This is as much to do with the re-registration of doctors as it is the new accreditation procedures to ensure well-trained doctors in the first place. Indeed, this process, which was designed to ensure continued public confidence in the quality of the health system (a political hot potato, as noted

⁴ Professor Sir Roy Meadow (June, 2005) is accused of professional misconduct because of allegedly giving misleading evidence in the trial of women who were initially convicted of killing their babies and then subsequently cleared. This is a high profile case in the British media. (See BBC, 2005).

⁵ The cases of Clifford Ayling and Richard Neale.

above, which focuses on waiting lists and other politically motivated targets for hospitals) has been side-tracked by the Shipman affair.

The Task Force wishes to ensure that current and proposed changes including assessments, revalidation and the early warning system are implemented with regard to their principles of good practice. From 2001, all doctors in or under contract to the NHS will be required to participate in annual appraisal and clinical audit. This will underpin and provide much of the data to support the GMC's 5 yearly revalidation process...The Task Force also refers to the quality assurance arrangements that have been developed to provide better protection for patients and to ensure high quality standards in the NHS. These will work alongside the modernised and more accountable professional self-regulatory arrangements, which we will expect to see developed.

The upshot is that the pressure on the GMC to increase its own accountability and that of every practitioner in the profession has made it hard to disentangle the pressures on changes in educational evaluation from those impacting on re-registration and ongoing monitoring of practitioner competence.

On one hand, the new quality assurance procedures are literally detached from the broader registration issues by being located on a micro-site within the GMC's website. The proposed and initially-implemented approach is outlined below. On the other hand, the whole thing may be swept away by yet another consultation announced in May 2005, in the aftermath of the fifth review of the Shipman affair. The specifics and implications of this new consultation are set out below, following the exploration of the new approach to quality assurance of medical education, initiated in 2005 following pilot reviews in 2004. As will also be outlined in the conclusion, the GMC's approach makes limited use of the QAA subject review (QAA, 2000) and, in effect, the latter was a temporary diversion from the main issue. However, it does reflect QAA concerns in emphasising the need for robust internal as well as external quality assurance mechanisms, as reflected in the *Principles of Good Medical Education and Training* (GMC, 2004b).

The new quality enhancement process is supposed to maintain stringent control of medicine while giving more responsibility to education providers. The proposed changes, that encourage guided self-reflection, more delegated responsibility but ultimately more external control are intended to walk this unenviable tightrope. The approach, as will be shown below, for medical accreditation is a type of controlling quality audit.

Tomorrow's Doctors

The GMC sets standards to describe the knowledge, skills and attitudes that new doctors should have. The GMC is also required to ensure that these standards are met before registering people as doctors. The latest standards are set out in *Tomorrow's Doctors*, first published by the GMC Education Committee in December 1993, recently revised in 2002 (with a publication date of 2003) and scheduled for revision in 2006. The guidance advocated the development of a curriculum comprising a core component and special study modules.

The main areas covered by *Tomorrow's Doctors* are:

- curricular outcomes: the principles of professional practice, outcomes;

- curricular content, structure: the scientific basis of practice, treatment, clinical and practical skills, communication skills, working environment, medico-legal and ethical issues, disability and rehabilitation, the health of the public, the individual in society;
- delivering the curriculum: supervisory structures, teaching and learning, learning resources and facilities, student selection, student support, guidance and feedback;
- assessing student performance and competence, principles of assessment, assessment procedures, appraisal, student progress;
- student health and conduct: confidentiality for medical students, the responsibility of medical students to protect patients, the responsibility of other doctors to protect patients, the responsibility of universities to protect patients;
- putting the recommendations into practice: what the law says about undergraduate education, UK law, European Union law.

However, despite prescriptive content, the GMC does not to prescribe educational approaches to pedagogy. Institutions can adopt, for example, a problem-based approach or a more traditional didactic approach to delivery, or anything in between, subject to quality controls. The GMC considers the diversity of approaches to delivering undergraduate medical education in the UK to be one of the reasons why it is held in such high regard abroad. Having said that, there appears to be a growing pressure towards more student-centred pedagogy.

Quality assurance process

Traditionally, the GMC adopted an inspectorial approach to checking standards. However, the GMC is moving away from inspectorial approaches to accrediting courses to quality assurance approaches with more emphasis on a process of continual engagement and continual improvement. The quality assurance process is in being reformed following two rounds of informal visits (the first 1995–1998 and the second, 1998–2001) to all established medical schools. The new process was trialled in three volunteer medical schools (Aberdeen, Birmingham and Liverpool) in 2003 and 2004.

In the past, statutory duties have been met by carrying out a range of different activities, including:

- a. Inspection of qualifying examinations held by UK universities with medical schools. Last inspected between 1982 and 1994.
- b. Informal visits to UK universities with medical schools. The last round, designed to consider the implementation of the GMC's recommendations on undergraduate medical education (*Tomorrow's doctors*) and on the PRHO year (*The New Doctor*) took place between October 1998 and April 2001.
- c. Written monitoring. This took two forms: first, summaries of how the universities have addressed the recommendations in GMC reports of the informal visits. Second, information requested annually from universities about the primary medical qualifications they award.

The new quality assurance process will ask each medical school how they are meeting the standards set out in *Tomorrow's Doctors*. Furthermore, medical education is also subject to evaluation by the Quality Assurance Agency for Higher Education (QAA), discussed below.⁶

Previous approach

The GMC undertook a series of visits between March 1995 and March 1998 to then existing 25 medical schools in the UK to monitor their response to the recommendations in *Tomorrow's Doctors*, which, *inter alia*, had identified an initial implementation period of five years from the date of publication. However, due to the length of the undergraduate course, there was a flexible approach to those schools that had not begun the process of curricular reform prior to the publication of the new guidance. Nonetheless, every medical school had to show the GMC evidence of real progress towards meeting the goals and objectives laid down by the Committee. The GMC published summary reports and an overview of the visits to show progress towards the recommendations in *Tomorrow's Doctors*, to identify obstacles to change and examples of good practice (GMC, 1999).

The visits, in the late 1990s, were conducted by teams with an appropriate range of medical expertise and knowledge. All teams comprised a leader and two or three visitors, who were usually either members of the Education Committee or members of Council. To facilitate consistency between the visiting teams, only two leaders were appointed and they undertook, between them, to lead all 25 visits, collaborating on two of them to ensure similarity of approach.

Two-to-three months before a visit, schools were asked to complete a questionnaire and return it with supporting documentation, which formed the basis of the two-day, on-site visit. The first day was devoted to the undergraduate curriculum and the second to the final year of basic medical education (the pre-registration house officer year).

At each school, the visitors had meetings with key staff involved in teaching and in implementing the undergraduate curriculum, and met students drawn from each stage of the course. Following each visit, a report was prepared for the GMC Education Committee, setting out the findings of the visiting team, including areas of good practice and suggestions for change. The reports were treated as confidential to the institution visited, although the GMC requested permission to share with other institutions information about the good practice identified by the visitors. A version of these reports are now available on the GMC website.

Approximately one year after a visit, the GMC wrote to the schools to ask how they had addressed the recommendations made in the visiting team's report. Their responses were considered in detail by the Sub-Committee on Assessment and Monitoring (SCAM) and then reported to the Education Committee. The information so obtained was taken into account when considering the sequence of the second-round of visits to medical schools, which began in autumn 1998.

⁶ The QAA is also undertaking a major review of healthcare programmes as part of a contract with Skills for Health, in partnership with the Department for Health (DH), Nursing and Midwifery Council (NMC), the Health Professions Council (HPC) and the Strategic Health Authorities (SHAs). This review process, known as Major Review, is part of the Partnership Quality Assurance Framework for Healthcare Education. However, as it deals with non-medical aspects of health care it does not impinge on those areas controlled by the GMC.

The GMC requested written submissions about progress from schools that would not be visited until later in the cycle. This was done to ensure that the GMC were properly informed about the work being undertaken in these institutions. These submissions were reviewed in detail by SCAM, and provided useful background information for the more extensive informal visits themselves. Where the GMC felt uncertain about aspects of the information provided, they organised short, on-site visits to obtain clarification.

In October 1998, the GMC began a series of visits to universities with medical schools, and associated postgraduate deaneries, to monitor the implementation of *The New Doctor* (published 1997), which set out expectations for the training of pre-registration house officers (PRHO) as well as identifying the components of a high quality PRHO post. These visits also monitored further progress on undergraduate medical education, *Tomorrow's Doctors*. This involved 23 visits, which were completed in April 2001.⁷

At around the same time, the Quality Assurance Agency for Higher Education (QAA) was undertaking its subject reviews of medicine. The GMC and the QAA have different agendas. The GMC agenda is about control, accountability and accreditation. The QAA agenda is about reviewing the quality of provision at a subject level, supposedly on the basis of fitness for purpose. It explores six aspects of provision: curriculum design, content and organisation; teaching, learning and assessment; student progression and achievement; student support and guidance; learning resources; quality management and enhancement. In essence these dimensions are tested by exploring the extent to which the student learning experience and student achievement, within each aspect of provision, contribute to meeting the objectives set by the subject provider (QAA, 2000).

Reviews of the quality of the educational provision in medicine were carried out by teams of subject specialists.⁸ QAA conducted eleven reviews in conjunction with a visit by the GMC. Visits to students working in placements in hospitals, community health care providers and general practice were also carried out. Student groups ranged in size from four students on a part-time postgraduate programme to over 1,000 full-time students at the undergraduate level. Some part-time postgraduate programmes also recruit large numbers of students. The reviewers approved all of the

⁷ Aberdeen, 2000; Belfast, 1998; Birmingham, 1999; Bristol, 2000; Cambridge, 2001; Cardiff, 1999; Dundee, 1999; Edinburgh, 2000; Glasgow, 1999; Leeds, 1997, 1998; Leicester, 1999; Liverpool, 1999; London: Barts & Royal London, 2000; Guys, Kings & St Thomas, 2000; Imperial, 2000; St George's, 2000; Royal Free & University College, 2001; Manchester, 2000; Newcastle upon Tyne, 1998; Nottingham, 2000; Oxford, 2001; Sheffield, 1998; Southampton, 1999.

⁸ The QAA visits were as follows (as reported on the QAA website (document number)): University of Newcastle upon Tyne, October 1998 (Q6/99); The Queen's University of Belfast, October 1998 (Q69/99); University of Leeds, November 1998 (Q56/99); University of Sheffield, November 1998 (Q60/99); University of Derby, November 1998 (Q85/99); University of Birmingham, January 1999 (Q98/99); Royal Free and University College Medical School, February 1999 (Q192/99); University College London, February 1999 (Q187/99); University of Liverpool, March 1999 (Q149/99); University of Leicester, May 1999 (Q188/99); University College London, Institute of Child Health, October 1999 (Q43/2000); University of Bristol, November 1999 (Q79/2000); King's College - Institute of Psychiatry, November 1999 (Q124/2000); University of Southampton, December 1999 (Q104/2000); St George's Hospital Medical School, January 2000 (Q170/2000); London School of Hygiene and Tropical Medicine, January 2000 (Q198/2000); Imperial College of Science, Technology and Medicine, February 2000 (Q199/2000); Queen Mary, University of London, February 2000 (Q211/2000); University of Manchester, March 2000 (Q319/2000); King's College London, March 2000 (Q290/2000); University of Cambridge, May 2000 (Q310/2000); University of Oxford, May 2000 (Q328/2000); University of Nottingham, March 2002 (Q588/2001).

undergraduate provision that they evaluated. The GMC's sphere of interest is the medical schools. This does not entirely overlap with the QAA who have undertaken reviews of these schools plus the University of Derby's pharmacy programmes. While co-operating in these QAA reviews, it seems that the GMC makes little use of them currently in their own processes.

Although these evaluations were often undertaken in partnership (or at least simultaneously) the reporting was entirely separate with minimum of cross- referencing. For example, in the QAA Report on the University of Leeds (1998) the GMC is mentioned just three times: first to say that 'the review visit was undertaken at the same time as the General Medical Council (GMC) curriculum monitoring visit' (QAA 1998, para 1), although in no way implying they were working together. Second, that 'The School has responded to the recommendations of the GMC set out in 'Tomorrow's Doctors' with a measured, evolutionary approach that is designed to ensure that the undergraduate curriculum will take full account of these by 1999' (QAA, 1998, para 9) and, third 'The School states that its aim is to deliver the current undergraduate course in the spirit of the GMC's recommendations, but the reviewers consider that this aim is not yet met.' (QAA, 1998, para 10), which is not surprising in view of the timetable set out in 1998.

Similarly, the GMC report on the visit had little to say about the QAA:

The visit lasted two days. The first day was concerned with the undergraduate curriculum, and involved us in collaborative working with a Quality Assurance Agency (QAA) team that was simultaneously conducting a review of medicine at the University. The second day focused on the provision made for general clinical training. (GMC, 1998, para 3)

A second mention was linked to the sharing of documentation required of the institution:

Prior to the visit the School provided us with background material including the Self Assessment Document prepared for QAA visitors. Members of the QAA team were supplied with copies of the completed GMC questionnaire that the School had produced for our visit. (GMC, 1998, para 6)

The other two mentions indicated that, on the first day, members of the QAA team joined the GMC visitors (not the other way round!). (GMC, 1998, paras 9, 141)

Neither report referred to the other and it seems that despite degrees of overlap these processes seemed to have little synergy. The GMC review explored the PRHO year as well as undergraduate training, the former being beyond the scope of the QAA visit. On the undergraduate front QAA approved the quality of education in medicine at Leeds although two areas were graded only 2 (out of 4) and a total rating of 18 out of 24. The GMC were also less than impressed, having visited a year earlier and expressed concerns about the speed of evolution of the curriculum. It noted

136. There are a number of areas of good practice in the current curriculum. The use of clinical skills centres and bed-side teachers to assist students to develop their clinical skills is praiseworthy. We were also impressed by the student body, a view clearly shared by the NHS managers we met on the second day of our visit.

137. However, little has changed since our last visit. The current curriculum exhibits a paucity of vertical and horizontal integration, and the pre-clinical and clinical phases are still clearly discernible. While plans for revising the curriculum are being developed little has been achieved, and a major effort is required to ensure that the changes proposed will be

implemented in line with the intended timetable.

138. The School needs to consider whether its supervisory structures are appropriate for implementing change. Staff are clearly making great efforts to develop plans for the new curriculum, and it is vital that effective mechanisms are in place to secure the desired outcome. We look forward to hearing how implementation of the new curriculum is progressing in a year's time.

The GMC and the QAA reports noted similar areas for improvement, although the former was more detailed and somewhat more directive. Given that the QAA subject reviews have ended (and there was never any certainty about a second round or any follow-up that involved sanctions) and that the GMC is a powerful regulatory body that is not going away, it seems certain that the University of Leeds will have focused on the specifics of the GMC visit outcomes rather than that of the QAA.

However, there is a general concern on the part of the GMC to ensure that appropriate quality assurance processes are in place and that medical schools are equipped to deal with external monitoring of any kind. For example, the GMC report on the University of Birmingham (GMC, 2004e) noted, albeit tucked away under 'other issues' in para. 69, that:

There were a number of issues emerging from the 1999 GMC and Quality Assurance Agency visits, including assessment, integration and identification of core, which had not been fully addressed yet by the School. Visitors were not sure whether the mechanisms were in place to respond sufficiently rapidly to legitimate outside criticism.

Indeed, the *Principles of Good Medical Education and Training* (GMC, 2004b, paras 26–33) note that:

There must be rigorous and evidence based quality assurance (QA), both internal (IQA) and external (EQA), to ensure that standards are being maintained, curricula are being continually reviewed and good practice is being shared.

It adds that QA processes should be able to show that they add value. Repeating earlier advice (GMC 2002a) it states that QA processes should be, efficient, valid, reliable, convenient, fair and focused, with a 'clear statement of QA responsibility for the different aspects of each programme'. QA processes should ensure that the students and doctors provide information and opinion on their education, training, supervision and clinical experience. The processes should be transparent, flexible, reflective and evolve 'in response to diversity and innovation or constructive criticism'. Futhermore:

The EQA should confirm the evaluation of processes and outcomes of the IQA, and build upon them. QA should support the creation of common data sets and a resource for innovative practice and the sharing of information.

A new approach

The GMC has been developing its new approach for half a decade, taking into account the visits that began in 1998. However, the approach to evaluation and accreditation of undergraduate and PRHO education is tied up closely with changes to overall regulation of the profession and the attempt to introduce a more ostensive lifelong learning, continuous professional development element.

In making its reforms to the quality assurance of education, the GMC intended a shift to a more continuous engagement that emphasises dialogue rather than checking and that empowered institutions encouraging more reflection and engagement with quality as opposed to accreditation issues. Furthermore, the new quality assurance processes are also expected to engage with the government's widening participation agenda. However, the process has been embroiled in the wider politics that have impacted on the GMC regulatory process as a result of high-profile cases that have, with the aid of a good deal of negative media reporting, led to a public 'crisis of confidence' in the medical profession. This at a time when the GMC is going through a lengthy process of structural reform (GMC, 2000; 2002b)

The new approach was proposed in 2002, piloted over the next 18 months and encoded on the new GMC *Quality Assurance of Basic Medical Education Extranet* (GMC, undated). The aims of the process are to:

1. Make sure that the outcomes in *Tomorrow's Doctors* are met.
2. Identify examples of innovation and good practice.
3. Identify, discuss and resolve issues of concern.
4. Identify changes that need to be made and a timetable for their introduction.
5. Promote equality and diversity in medical education. (GMC, 2004a)

The objectives of the process are to:

- a. Monitor changes to curricula, assessments and staffing through information received annually from each school.
- b. Make sure that medical schools tell the GMC about any new courses they are developing and seek formal approval for these.
- c. Allow issues of common concern in undergraduate medical education to be identified, discussed and resolved, thereby contributing to the on-going review of *Tomorrow's Doctors*.
- d. Produce evidence-based visit reports on whether schools meet the requirements in *Tomorrow's Doctors*.
- e. Identify examples of good practice for widening participation in medical education.
- f. Provide evidence that will allow the Education Committee to make a recommendation to the Privy Council whether a university or institution should be added to or removed from Section 4 of the Medical Act 1983 that allows them to award a primary UK medical qualifications. (GMC, 2004a)

The pilots, during 2004, to the volunteer sites of Aberdeen, Birmingham and Liverpool were somewhat curious in that they surprised the volunteer schools by their focus, without clearly

identifying, at least in a public documents, what they revealed about the proposed new process.

Professor William Doe, Dean at Birmingham Medical School in the published letter of response to the Final Report of QABME Visits to Birmingham Medical School for 2003–04, stated:

The School has found the QABME visits to be a worthwhile and beneficial process and has given us the opportunity to critically assess our existing provision. We were, however, a little surprised at the extent to which our own educational processes were reviewed, given that, when we volunteered to be a pilot site, we believed that it's purpose was, primarily, to assist you in optimising your new processes. (GMC, 2004e)

Reading between the lines one might infer a similar reaction from Professor Mike Greaves, Head of School of Medicine, at Aberdeen Medical School:

The School was, of course, aware of the likely recommendations and areas that the Education Committee would ask to be considered further from your earlier drafts and also from discussion with the visiting panel in June. We have, therefore, already been considering the issues raised.... We have enjoyed taking part in your pilot process and have found the process both challenging and refreshing. The visits and the production of supporting documentation has encouraged us to re-evaluate our curriculum and already accelerated progress in particular areas. Above all, the input from the visiting team was always both stimulating and enjoyable. (GMC, 2004f)

Professor Anne Garden, head of school at Liverpool Medical School, provided somewhat more feedback on the process itself in her response of December 2004. She stated:

I thought that the QABME process worked well — certainly the visitors were very thorough in their duties — although we did feel somewhat over-visited! However, at all times they were very professional and the process was carried out in a robust yet supportive way as I think the report bears out. I certainly have no regrets that we volunteered to be a pilot site. (GMC, 2004g)

She did have two major concerns, though:

- i. There should not be mention made in the report of things that have not been discussed with the School. The obvious example is the external examiners reports — what we do with them and what changes have been made as a result of them. We could have easily provided evidence about that — but were never asked.
- ii. Evidence should be available for comments made. Again the examples would be the comments about the variability of the clinical sites and the feedback to students. I have tried hard since the visits to find out the basis of these comments to no avail. This is unhelpful — it may be these things are true and no-one is brave enough to tell me to my face — in which case I will not be able to put it right and it will catch us again next time — or it may be that this was a single unhappy student or at worst a small group who are unhappy but not representative of the whole — in which case it probably should not have been in the report. When I did QAA (not that I am saying everything we did in those visits was exemplary) we were not permitted to put anything in the report that could not be 'triangulated' — we should apply the same rigour to our comments. (GMC, 2004g)

The reference to the QAA subject reviews, in which Professor Garden was an assessor, is a rare case in the medical evaluation literature suggesting that QAA provides an example of good practice.

It is not at all clear how the pilots informed the QABME process nor indeed what the relation between the QABME process and the *Principles of Good Medical Education and Training: Draft for Consultation*, issued in August 2004, which does not directly mention QABME, although it does refer to quality assurance, both internal and external. Furthermore, the report, *Quality Assuring Undergraduate Medical Education - An Overview*, issued in February 2005, neither mentions the pilots nor responds to, for example, the concerns about over-visiting.

In the new approach, the GMC will arrange a series of visits, over the period of a review year, to the medical school to confirm how they are meeting the standards set out in *Tomorrow's Doctors*. The key objectives are to ensure that the curricular outcomes (attitudes, behaviour, knowledge and skills) are achieved and demonstrated by new graduates and that for the PRHO year, to ensure that systems are in place that allow the GMC to be confident that only those doctors who are fit to receive full registration do so.

The GMC will then publish their views of what the school is doing well and where the school may wish to consider further developing its work. Reports of visits to medical schools will include a statement from the visitors about whether the standards at the school visited are appropriate. As of Summer 2005, no reports have been published as it is too soon in the new process. Preliminary visits for Leeds, Newcastle, Queen's University Belfast and Royal Free University College (London) were completed in October 2004 in preparation for visits in 2005 to these were added visits to the new schools. The first wrap-up visits took place in July 2005 at Newcastle and Brighton Sussex Medical School.

To some extent, the new process represents a shift from inspection to audit of internal processes, albeit a tightly controlled audit that can invoke sanctions in the last resort and which, unlike most quality audits, also passes judgement on the adequacy of the standard of medical education and training.

Following the on-site visit, the GMC will ask the school to update information each year and the school will be visited again at least twice in any ten year period. It is intended that the quality assurance process will be a continuous exercise. The process will involve:

- a. Annual requests for written information from universities describing any significant changes from their last return.
- b. Regularly (at least twice in every ten years) the GMC's Education Committee will visit every Medical School. It was proposed that on the designated visit year, there would be a series of site visits to universities focussing on issues identified in the annual returns, this would culminate in an one-day synoptic visit to universities involving all team members.
- c. Regular reports to the Undergraduate Board on the information collated. (GMC, 2002a; 2004)

Outwith this process, if a school makes significant changes to its curriculum, then special arrangements come into play. Furthermore, the new medical schools will face a similar but more intense régime of quality assurance. The visiting cycle will be completed every year for the first cohort of students. This will result in annual reports that will allow the Education Committee to gauge the progress of each school, and compare progress across the new schools. The annual report for the final year of the first cohort of students will be the final report that is presented to the Education Committee and sent to the Privy Council with the Committee's recommendation about the awarding status of the medical school concerned.

Information

All universities will be asked to provide baseline information before the first cycle of visits starts, using a standardised template. This information, which will be updated each year, will be assessed by the office working in conjunction with the Undergraduate Board, a sub-committee of the GMC's Education Committee. The proposed information for *undergraduate education* that will be requested annually was initially to be the following (GMC, 2002a):

- A description of how their curriculum meets the requirements in *Tomorrow's Doctors*.
- A description of their assessment system and their internal QA processes:
- External examiners' reports covering the last three years prior to a visit, including a list of the issues identified by external examiners during that period and the action taken by the university in response to these issues.
- A report from the student body at the university giving its views on the curriculum and the assessment and QA systems.
- A report from NHS partners commenting on the quality of the university's recent graduates in terms of their attitudes, behaviour, knowledge and skills.
- A copy of their QAA institutional review report.

This was modified in the 2004 guidance document. Each year all medical schools will be asked to:

- Provide information about how their curricula and assessments meet the requirements in *Tomorrow's Doctors*.
- Identify any significant changes to their curricula, assessments or staffing levels
- Highlight issues of concern, corrective action taken and proposed solutions
- Identify examples of innovation and good practice.
- Respond to issues of current interest and debate in medical education including the promoting equality and valuing diversity (GMC, 2004).

A standardised QAMBE questionnaire will be used to collect this information.

The changes, from the proposed information requirements (2002a) to the guidance document requirements (2004c), are significant. The focus in the latter is on conformance to curriculum and assessment, changes in practices as well as highlighting good practice and responsiveness to debates and policy. This contrasts with an initial proposal that not only wanted curriculum conformance but emphasised system procedures and external commentary.

The initial proposal for information relating to the *PRHO year* was that it would include:

- A description of the school's strategy for delivering high quality general clinical training that also explains how the educational and training objectives in *The New Doctor* are being met.

- Information about procedures for quality assuring PRHO posts.
- Information about general difficulties arising in relation to the provision of PRHO posts across the region, and the action taken in response to these issues in the year of the visit.
- Information about specific posts that have caused problems and the action taken to resolve these difficulties.
- Details of how the school liaises with their NHS partners in agreeing educational objectives and service targets.
- A written report from the university's current PRHOs giving their views on the quality of education and training provided.
- Feedback from the university's recent past PRHOs (possibly in the form of a summary report of the exit questionnaires PRHOs complete) giving their views on the quality of education and training they received when PRHOs.
- Copies of any evaluation surveys about their PRHO training that have recently been undertaken. (GMC, 2002a)

Although this is extensive, if there is no change, on an annual basis, to any of the information requested for basic and PRHO education, then the university would simply provide notification to that effect.

Site visits

It was proposed to have a series of site visits to universities, focussing on issues identified in the annual information returns. Depending on the range of issues to be covered, there might be up to three or four two-day site visits undertaken over the course of the year selected for the visit. It is proposed that institutions are visited every five years 'unless innovative developments or concerns about provision required an earlier visit' (GMC, 2002a).

According to one part of the GMC website, these visits will be carried out over an academic year by pairs of visitors looking at particular areas. Another part of the sites states "Visits will be rigorous and reliable and will be carried out by a small group of trained visitors who will be recruited against competencies". The visits would involve:

- meetings with university and deanery staff;
- observation of teaching and assessments;
- sampling of student assessment exercises (including, written scripts, portfolios and logbooks);
- meetings with students and PRHOs.
- observation of university and deanery procedures for approving PRHO posts.

- evaluation of university and deanery systems for ensuring that only those doctors who are fit to receive full registration do so. (GMC, 2002a)

In addition to specific-focus visits there will be a synoptic visit. This will be a one-day visit to universities involving all team members. This will be undertaken at the end of the academic year in which the university is being visited and will provide the opportunity to draw together and review all the issues considered during that year and for clarification of any outstanding issues prior to publication of the final report. The timetable for visits will be constructed for a ten-year period. Changes to the norm of two visit years per decade will be dictated by pre-set criteria.⁹

The 2004 guidance has a different slant on this. The shift was in response to the choice and delegated-responsibility agendas, although as will be shown, the re-emergence of accountability has stalled progress. In the 2004 guidance, site visits are less inspectorial and are part of the information gathering process which has three stages (GMC, 2005a, pp. 5–6). Stage 1, collecting information (June to December); stage 2, confirming information (January to July); stage 3, integrating information and making judgements (June to August).

As of 2004, selected schools were contacted in June. GMC administrative staff undertook a preliminary visit to explain about the QABME process. In September, the schools received the QABME Questionnaire requesting information in a standard format, to be completed and returned by 1 October. This information is shared with the GMC Visitors teams who formulate action plans, which will include a series of visits to take place between January to July the following year.

This process will allow visiting teams to collect information, explore issues, and observe parts of the teaching and learning process in a systematic and explicit way. Teams will be provided with practical guidance to help them to collect, confirm and evaluate information so that the process is based on the requirements set out in *Tomorrow's Doctors* and managed consistently across all schools. (GMC, 2005a, p. 6)

Visiting teams undertake all three stages and produce a final report on each school that will be submitted to the Education Committee.

Reports

Regular reports will be made to the Undergraduate Board on the information collated. These reports will be short and evaluative (setting out conclusions rather than the factual information on which these conclusions are based) and will be formatted against the headings in *Tomorrow's Doctors* and *The New Doctor*.

The final report will include a statement about the sufficiency of the standards at the school visited. An evidence base for the report, based upon the school's response to the template, will be agreed and published with the final report (GMC, 2004).

The proposal is that the member of staff who accompanies visitors should draft these reports for final approval by the team. This arrangement will give the office greater consistency in the

⁹ These criteria are: (1) failure by the university to respond to GMC recommendations within an agreed timeframe; (2) issues arising from assessment of information received via the annual returns; (3) issues arising from other reports that the GMC receive about the university; (4) The development of new and innovative educational and training systems; (5) The length of time since the last visit.

production, form and style of the reports (GMC, 2002a). In the interests of transparency and public accountability it is proposed that these reports of outcomes should be published after the institutions have had the chance to check their factual accuracy.

As required by the *1983 Medical Act*, a copy of the formal report submitted by each visiting team together with any observations on it made by the body visited will be forward to the Privy Council together with the Education Committee's recommendation about the awarding status of the university or institution concerned.

Continual monitoring of education provision and ongoing practice

The GMC's mantra in all this development is continual improvement, both for education providers, practicing doctors and their own quality processes. They intend to build into the arrangements, systems that will allow them continually to improve the quality assurance process. Clear communication with medical schools will be important in making sure that the process works and is amended. In particular, the GMC needs to ensure that medical schools understand the process, provide the information required and give feedback about the process and about individual members of the visiting teams. Schools will, therefore, be requested to keep a log of issues about the process, so that concerns and difficulties can be identified, captured and addressed in a managed and consistent way. To this end, the GMC introduced a *QAMBE Monthly Update* available online.

Each medical school, regardless of whether it is being visited in the current cycle or not, will have a named GMC officer as a contact point with the GMC. This individual will work with a named contact at the school to ensure the smooth operation of the process and to facilitate the free flow of information (GMC, 2005a, p. 7).

It will be instructive to see how the proposed continuous evaluation works out in practice. In other spheres, notably QAA evaluation of higher education provision in England, the idea of a continuous dialogic audit process has resulted in rather sharp reaction from the potential auditees, on the grounds of unwarranted intrusion and bureaucratic burden. There are already hints of this, in the response to the pilot from Liverpool, mentioned above, about being over-visited.

The key difference in the medical setting may be that the proposed new approach is seen as a lessening of control and that, in any event, the medical schools have little choice but to comply given the stringent powers, backed by legislation, of the GMC. Whether, though, the medical schools adapt to a continuous dialogue on quality and standards, or simply comply with a new inspectorial régime, remains to be seen.

Although the GMC comes in for criticism, this tends to be directed at the way it controls doctor re-registration rather than any criticism from the academic community about the accreditation process. It is hard to locate any critiques of either the old system of accreditation of medical education or the proposed new continuous engagement approach. The latter may be because people have been biding their time, waiting to see the outcomes of the first round of the new QABME process.

However, the GMC's own survey of the QABME process suggests a considerable degree of support. Throughout the introduction of the new quality process, the GMC have 'sought feedback from GMC staff, Visitors, Medical Schools, visit observers and other independent organisations such as the Better Regulation Review Group (BRRG)' (GMC, 2004a). The survey of Medical

Schools was conducted over the telephone and, for Visitors, by e-mail. The hope was that ‘this method of approach will encourage communication about the effectiveness of the pilot programme’. The GMC (2004h, p. 2) report notes that survey replies are ‘predominantly positive’ and ‘constructive suggestions or areas of concern have been taken forward as part of the continuous improvement programme’. There were ‘no surprise issues arising from the survey’.

Most of the questions were about the specific of the process, such as the helpfulness and timeliness of information received, the relevance, conduct and feedback of the visits. All of this was reported as satisfactory. One question asked ‘Do you think the GMC’s quality assurance process is effective at meeting the GMC’s statutory responsibilities as set out in *Tomorrow’s Doctors?*’: 30% were neutral while the remaining 70% thought it effective. The neutrals, seemed to be thinking further ahead as respondent noted:

‘We won’t know until our process has been finished in 2007 if it has been effective or not.’

‘Appears to be thorough although we won’t know until our process has been finished in 2007 if it has been effective or not’

‘We do not feel we can comment upon this until we have produced our first graduates.’

Overall, the survey results were positive about the process and its ability to meet its basic aim, the monitoring of the curriculum. There was slightly more concern, though, about the reporting, highlighting good practice and new initiatives. To some extent this reflected concerns raised in the responses to the pilots. In all, 30% of respondents did not think the report on the process was as fair as it could have been and 60% thought that not all their areas of good practice were highlighted through the process. Only 60% thought that the process was effective ‘as a way of encouraging schools to address contemporary concerns including equality and diversity, patient-centeredness, learner-centeredness, inter-professional learning and preparing students for the permanence of change in medicine and social expectations’.

The relative failure to identify good practice and the limited impact on contemporary concerns must raise questions about the nature of the exercise. This is exacerbated by the clear concerns by respondents about the perceived cost of QABME ‘in terms of finance and resource’. Example responses include:

‘HUGE amount of time. Very wide ranging things asked for – perhaps be better for visits to focus on specific aspects?’

‘It took one officer full time for one month. In addition there were two weeks Senior Staff time, expressed in costs as one person. We do not have an exact figure at present.’

‘We don’t have an exact figure but it did cost an awful lot in terms of staff time.’

‘Assembling the senior staff for meetings who are on high salaries will have been costly. There were also additional costs such as photocopying, couriers etc.’

‘Approximately £50,000.’ (GMC, 2004h).

The high profile concerns and the budget expenditure reflect the huge emphasis that is placed on the regulation of the profession, of which the accreditation of initial education is a relatively small part. However, the ongoing monitoring of practitioners itself, it is intended, will henceforward

involve a more directive continual learning element, which the GMC will oversee. The intention, subject to further developments and confirmation, is essentially to encourage a self-reflective process on the part of practicing doctors, as far as possible linked into an authorised appraisal process. This would, if carried out as intended, mean that doctors would need to maintain a ‘folder’ outlining their activities and engagement with medical practice, including, in theory, direct feedback from their colleagues and patients via questionnaires.

New consultation

Just as the new system of assurance of basic education appears to be bedding in, a new consultation on medical education has been launched. Given its far-reaching remit, this is bound to have implications for the new quality process.

Following the 2005 GMC Conference, ‘Medical Education: From Here to Where?’, which included an opening presentation from The Right Hon. Lady Justice Janet Smith DBE, Chair of The Shipman Inquiry, the GMC proposed a further consultation on medical education. Among other things, Dame Janet Smith expressed her personal view supporting a move to put students on the medical register in order to establish early on that doctors have the right values and attitudes to practise a patient-centred medicine. The issue of curriculum content and of a national examination was also raised. As a result, the Education Committee is consulting on the strategic options for undergraduate medical education, exploring the ways medical education may change in light of a large number of social and clinical demands. The consultation, will be organised around three themes

- Should we have a national assessment for medical students, rather than medical schools continuing to design their own assessment schemes, subject to the constraints set by the GMC Education Committee?
- Should the GMC register students as well as doctors, and have greater control over the medical schools’ regulations for student fitness to practise in relation to their health and conduct?
- What should be included in the undergraduate curriculum and covered in the next edition of *Tomorrow’s Doctors*? What do we expect medical graduates to know and to do? (GMC, 2005c)

This consultation, which will run until 31 October 2005, includes themes that affect undergraduate curricula such as: putting patients at the centre of health care; student-centred education; learning and working with other healthcare professions; promoting equality and valuing diversity; how to prepare medical students for continual change in medical practice throughout their careers (GMC, 2005c).

The consultation is supported by Professor Sir Liam Donaldson, Chief Medical Officer, England who said:

There is no more important task in society than the education of doctors of the future. The welfare of patients, the quality and safety of care depend on excellence in medical education. I commend the GMC in launching this consultation to explore some fundamental questions in medical education. (GMC, 2005c)

Conclusion

The GMC is a very powerful and highly scrutinised regulatory body. The recent high-profile case of Professor Sir Roy Meadow is a indicative of the pressures on the organisation. Not only does the GMC regulate at all levels of practice, they are also in the process of reforming the ways in which they scrutinise ongoing practice and link that to continual professional development alongside changes in the accreditation and quality assurance of initial medical education. The three elements are interlinked and it is difficult to understand the complexity of the arrangements for medical education independently of the GMC's overall regulatory role. The intention to give medical schools more responsibility for their own quality is to some extent confounded by the need to ensure accountability.

Indeed, when Professor Graeme Catto was elected as the GMC's President in 2001, the primary task was to communicate more widely the changes at the GMC. Professor Catto is reported to have said 'We have to get the public to understand what it is we're doing,' which would improve the public's perception of the GMC. Further, he said the medical profession itself needed better educating and training, and that improvements in that area were preferable to the GMC policing the medical profession. 'Policing is the least best option. Of course it's essential, but it's an admission of failure to go down that route.' (BBC, 2001).

Within this context, it is hard to draw comparisons with other forms of evaluation and quality assurance. The GMC are doing more than accrediting in their attempt to quality assure, accredit and control medical education as part of their remit to control the profession while being themselves a powerful regulator but subject to intense public and political scrutiny. The GMC is highly susceptible to government policy and political pressures, is continuously scrutinised, has to be accountable for itself and for the medical profession.

The GMC not only accredits medical education but also regulates the profession. This means that the accreditation of medical education operates within a legislative regulatory framework beyond that of most other quality assurance and accreditation processes. In the United States, for example, The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the Accreditation of post-MD medical training programmes within the United States. However it does not regulate the profession. Similarly, The Liaison Committee on Medical Education (LCME) 'is the nationally recognized accrediting authority for medical education programs leading to the M.D. degree in U.S. and Canadian medical schools' (LCME, 2005). Although sponsored by the Association of American Medical Colleges and the American Medical Association, the LCME has no regulatory function for the profession.

The New QAMBE approaches are not overly concerned with defining quality or even quality assurance. The key role of the process is not to judge academic excellence *per se* but to ensure appropriate levels of competence of graduating doctors. To that end it requires compliance on several fronts; not ably curriculum content, supervision, practical experience and vigilance in ensuring only appropriate students reach the stage where they may achieve registration. This is not so much about fitness for purpose, as the institutions and the programmes of study are not in a position to determine their own mission-related purpose. It is more about quality as transformation

— transformation to competent reflective practitioners — and about excellence, ensuring that medical education in the UK maintains its excellent status around the world.

Despite all the problems and scrutiny faced by the GMC through its period of reform, the only expressed concerns about the new quality processes comes from policy quarters, not from the institutions themselves. In the main, it the institutions, used to the idea of being subject to the inspection of a statutory regulatory body seems to be complying, and indeed embracing, the new methodology. Expressed concerns, as noted above, have so far been minimal and relate to too many visits during the audit year and the reservations about the methodology adequately highlighting and sharing good practice and of enabling and encouraging diversity.

The attempt to shift the balance of the new approach from constraint to empowerment — from an inspectoral and controlling methodology to one that encourages more dialogue and delegated responsibility for improvement, external circumstances continue to conspire to emphasise accountability, of both education providers and the regulator itself. This creates uncertainty and has a potentially negative effect on innovation.

In his recent study of the evaluations in Danish higher education (undertaken by EVA), Bjorn Stensaker (2004) explores the policy drivers. These are predominantly concerns of politicians about the accountability and standing of Danish education given the increasing institutional autonomy, the balance between supply of and demand for study places, and international comparability of programme standards. These are not unusual concerns of national agencies within Europe evaluating programmes across the sector. Indeed, as noted above, the QAA subject reviews in the UK had similar concerns (institutional autonomy apart) about quality, focusing on six dimensions that purportedly evaluated fitness for purpose.

Impact studies of quality in the general higher education setting are notoriously difficult to do, other than at the level of identifying documentary compliance and measuring the proportion of recommendations implemented. Stensaker's study of the Danish evaluations showed, for example that 60% of recommendations had been implemented. In the UK medical education setting, impact is a rather more deferred concept. Impact as compliance and implementing recommendations is, on the face of it, non-problematic as the institutions are observed directly until such times as progress towards implementation occurs. Sometimes recommendations, particularly relating to the implementation of new curricula can take some time given the length of undergraduate courses (five years), however, there is no question that such implementation will not take place. The real impact factor that the GMC has to address is further down the line — the competence and (absence of) malpractice of registered doctors.

The other factor that affects evaluations is 'game playing' and familiarity with procedures' that potentially render later cycles of evaluations less effective. It seems, in the case of UK medical education, apart from the change in processes which has led to more continuous engagement, there is little incentive for game playing or attempting to short-circuit processes as it is not in the medical school's best interests to be producing incompetent graduates. In short, the schools work closely with the GMC, despite being effectively controlled by it.

Whereas quality assurance of programmes in most higher education settings do not judge academic standards *per se* and most accreditation ensures minimum standards, the GMC approach is to ensure compliance across the board with the high expectations of provision set out in *Tomorrow's Doctors*, which includes academic standards and standards of competence as well as quality of the

learning environment. The combination of continuous audit with evaluation of standards is thus relatively unusual.

The aim of the changes to medical education accreditation and quality assurance in the UK is to focus much more on continual improvement, reflection and encouraging real ownership of the quality improvement process. However, in the current political climate, with the regulator itself under intense scrutiny, anything but compliance might be seen as a risky strategy. This reflects the contradiction in the President's statement (BBC, 2001) that policing the profession is both undesirable and essential. As enquiry and consultation pile on top of one another, the tenor of the times suggests that essentialism will overwhelm trust and dialogue. However, if medical education is to progress, to fully adopt a student-centred approach, new forms of pedagogy and continue to extend the portfolio of assessment techniques to better demonstrate competence of new doctors, which in itself will help to further protect the public, then the new approach will need to have an opportunity to flourish. The GMC prides itself on not prescribing delivery techniques and encourages student selection within the curriculum. If, in the aftermath of Shipman, the consultation supports a national examination, and effectively much closer control of the educational process, there may well be a retreat from innovation, the adoption of a compliance culture and the likelihood of the emergence of a controlling spiral similar to that in teacher education.

The emergence of the Teacher Training Agency (TTA), in the UK, as a regulator of teacher training followed high-profile concerns, mostly engendered through the reactionary press, that teacher education was encouraging innovation that 'endangered the education of our kids'. The TTA was developed to control teacher education and effectively bring in a national curriculum for teacher training, in line with the introduction of the national curriculum in schools. The approach adopted by the TTA became increasingly prescriptive. There was no question but that it required compliance, resulting in a lack of innovation and more importantly a lack of imagination, drive and innovation.

The Office of Standards in Education (OFSTED) undertakes periodic inspections of training provision alongside its ongoing inspection of the UK's schools.

We do have to guarantee that students obtain the required standards, both in practical teaching and in academic assignments. To do this we have to provide our own assessment to external inspectors (OFSTED) and they then crawl all over us to demonstrate whether we are 'Good, with outstanding features' (Grade 1) 'Good' (Grade 2) 'Compliant, but needs substantial improvement' (Grade 3) 'Non-compliant with the Secretary of State's standards' (Grade 4). (Hoskyns, 2000)

Indeed, teacher training in universities is about as far as one can get from the traditional model of academic freedom and autonomy. (Harvey, 2001)

The new proposals for the quality assurance of basic medical education offer a way of combining accreditation with quality improvement, which is relatively unique. There is a danger, though, that public accountability will be re-conceptualised as control rather than improvement and the new approach will founder on the rocks of national examinations and tighter prescription of curriculum content, leading to uninspired and conformist teaching and learning.

Resources for Policy Makers

- o Tomorrow's Doctors

http://www.gmc-uk.org/med_ed/tomdoc.htm#Clinical%20and%20practical%20skills

- o *The New Doctor*

http://www.gmc-uk.org/med_ed/newdoc.htm

- o QABME Questionnaire:

http://www.gmc-uk.org/qabme/about/procedures/formtemplates/frm_QABME%20Questionnaire%20for%20UME_5.0.doc

- o Quality Assurance of Basic Medical Education Extranet (QUABME) website

<http://www.gmc-uk.org/qabme/index.htm>

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