Securing the licence to practise: introducing a Medical Licensing Assessment a public consultation

Working with doctors Working for patients

General Medical Council

Medical licensing: The case for change

The public might be surprised if they knew that doctors wishing to practise in the four nations of the UK are not required to meet a common threshold for entry onto the UK medical register, or to pass a standard assessment to test their skills and competence.

Currently, there are three main routes to practice in the UK and differences in the standards required.

- **Students passing finals at UK medical schools** – While we regulate medical schools and lay down the outcomes that graduates must meet, there is no UK-wide curriculum or assessment process and final exams (finals) vary substantially between the established medical schools.

- **International medical graduates** – Many international medical graduates, holding primary medical qualifications obtained outside Europe, gain registration by taking our Professional and Linguistic Assessments Board (PLAB) test. Others use other ways to register which do not involve passing the PLAB test, primarily by holding a postgraduate qualification that we accept or through sponsorship by an organisation that we recognise for this purpose.

- **EEA graduates** – EEA graduates* are currently entitled to have their qualifications recognised here without any test of their competence due to European law.

The fundamental case for introducing a medical licensing assessment is to demonstrate that doctors entering UK practice meet a common threshold, no matter where they obtained their medical degree.

Recent developments have underlined the need to secure a common threshold for entry onto the medical register.

Firstly, we will watch closely what happens with Brexit and any ensuing developments to the UK constitutional settlement, as these might apply to the four countries of the UK. We have no view on the decision to leave the European Union as such, but have a long-standing position that we would like to be able to check that doctors coming to practise here from Europe meet the same standards as those who qualify in the UK and outside Europe.

Like international medical graduates from the rest of the world, EEA graduates play a critical role in our health services and we have no intention of erecting unnecessary

* EEA/Swiss nationals (or those with EU enforceable rights) who hold European primary medical qualifications.

obstacles to doctors wishing to practise in the UK. At the same time, being able to check that EEA graduates have the knowledge and skills we expect of all doctors when they come into the UK is critical to secure fairness for all those seeking to practise here. These checks would also provide assurance to patients and the public, employers and ourselves as the medical regulator.

If this were to be possible once new relations with the EU have been agreed, we would look to the UK Government to make amendments to our powers as set out in UK law via the *Medical Act 1983* and so enable us, among other things, to require EEA graduates to take the MLA in line with other doctors entering UK practice.

Secondly, there are major changes underway in medical education, most notably in England, which underline the case for a change of approach to its regulation in the interests of maintaining patient safety and assuring doctors' employers. The Department of Health for England has announced that up to 1,500 additional medical students will graduate from medical schools every year and medical school places are also increasing in Scotland with a new graduate entry programme.

Also, entirely new medical schools are being set up in the context of changes to the regulation of higher education and more may be established to provide the additional student places. It will be critical to make sure that medical graduates emerging from these new arrangements meet a common threshold for patient safety alongside their colleagues from existing schools and programmes. The MLA will supplement our existing systems for quality assurance by bringing a new focus on assuring the competence of individual graduates.

We believe the MLA will be a major step forward in providing greater confidence in doctors new to UK practice. It will bring benefits to patients, doctors already practising in the UK, doctors' employers, medical schools and also the UK medical students and overseas doctors wishing to practise in the UK.

What is this consultation about?

We're consulting on plans to establish a UK-wide Medical Licensing Assessment (MLA). This would create a single, objective demonstration that those who obtain registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.

We are an independent organisation that helps to protect patients and improve medical education and practice across the UK. As part of our responsibilities, we grant doctors their licence to practise in the UK.

Three routes to practice

Currently, there are three main routes to practice in the UK and differences in the standards required.

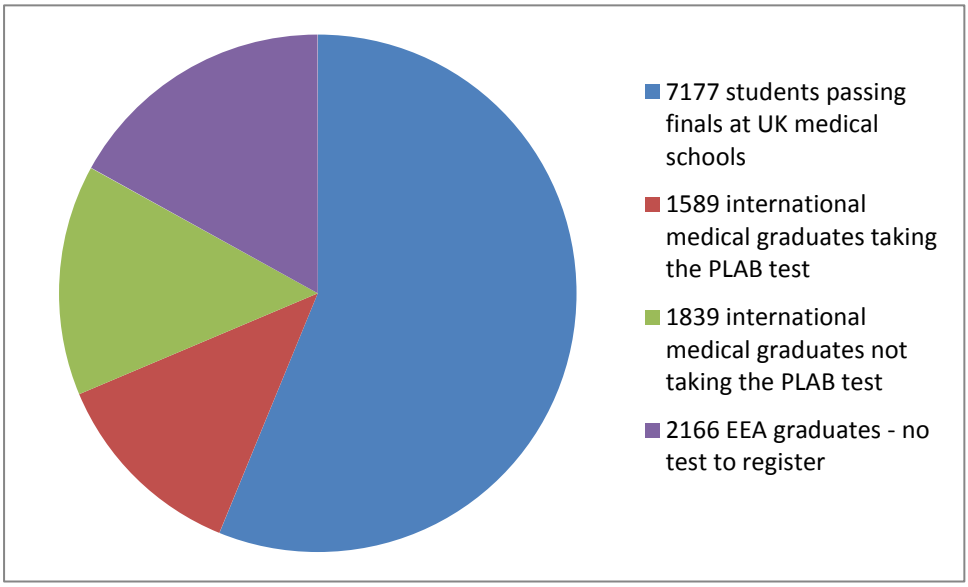
- **Students passing finals at UK medical schools** – in 2016, 7,177 UK graduates gained registration. While we regulate medical schools and lay down the outcomes that graduates must meet, there is no UK-wide curriculum or assessment process and final exams (finals) vary substantially between the established medical schools. A major expansion in student numbers is now underway, potentially involving wholly new medical schools as well as new programmes, sometimes delivered overseas.

- **International medical graduates** – in 2016, 1,589 international medical graduates, holding primary medical qualifications obtained outside Europe, gained registration by taking our Professional and Linguistic Assessments Board (PLAB) test. 1,839 international medical graduates used other ways to register, which did not involve passing the PLAB test – primarily by holding a postgraduate qualification that we accept, or through sponsorship by an organisation that we recognise for this purpose. International medical graduates must also satisfy other requirements, which include having obtained a medical qualification that we accept.

- **EEA graduates** – in 2016, 2,166 medical graduates from European Economic Area (EEA) countries gained registration. EEA graduates* are currently entitled to have their qualifications recognised here without any test of their competence due to European law.†

* EEA/Swiss nationals (or those with EU enforceable rights) who hold European primary medical qualifications.

† The figures cited on students passing finals at UK medical schools, international medical graduates and EEA graduates relate to those joining the medical register for the first time in 2016. They relate to the countries



Creating a common assessment that instils confidence

We intend that an MLA would create – for the first time – a common, objective assessment that would enable everyone, particularly patients and the public, to be confident that doctors new to practice have met the same threshold of competence.

There is emerging evidence that even among existing UK medical schools and undergraduate programmes there is variation in universities' finals despite our having relied on graduation as evidence of the knowledge and skills of UK medical students. This has been demonstrated through academic research* and through an audit we carried out. Also, the Medical Schools Council Assessment Alliance (MSCAA) has been researching the extent of variation in the standards set by UK medical schools for written finals as well as the diversity in their methods and processes for testing students' clinical skills. It is clearly now impossible for us to rely solely on finals to secure a common threshold for granting UK graduates a licence to practise.

where the doctors got their medical qualifications, not their nationality. For the UK medical graduates, nearly all the registrations were provisional.

* McCrorie P, Boursicot KAM. 2009. Variations in medical school graduating examinations in the United Kingdom: Are clinical competence standards comparable? *Medical Teacher* 31: 223–229; Devine OP, Harborne AC, McManus IC. 2015. Assessment at UK medical schools varies substantially in volume, type and intensity and correlates with postgraduate attainment. *BMC Medical Education* 15:146; MacDougall M. 2015. Variation in assessment and standard setting practices across UK undergraduate medicine and the need for a benchmark. *International Journal of Medical Education* 6: 125–135; Boursicot KAM, Roberts TE, Pell G. 2006. Standard setting for clinical competence at graduation from medical school: A comparison of passing scores across five medical schools. *Advances in Health Sciences Education* 11: 173–183; Boursicot KAM, Roberts TE, Pell G. 2007. Using borderline methods to compare passing standards for OSCEs at graduation across three medical schools. *Medical Education* 41(11): 1024–1031.

The fundamental case for a common assessment against a shared threshold has been underlined by recent developments.

- The UK's decision to leave the European Union may make it possible for us to test the knowledge and skills of EEA graduates wishing to practise here alongside UK candidates and doctors from the rest of the world.

- Medical education is going through dramatic changes with a major increase in student numbers and entirely new medical schools being established.

The MLA would introduce a test of applied knowledge as well as a test of clinical and professional skills. The pass mark would be set to demonstrate that the successful candidates have the knowledge and skills needed to be fully registered with a licence to practise in the UK. In addition to passing the MLA, under the current law applicants for full registration would need to show they have appropriate experience of practising medicine under supervision.

We envisage that all UK students would need to pass these MLA tests to get a primary medical qualification (a medical degree), although finals would continue to include examinations or assessments designed by the universities to reflect the variety of their curricula.

For international medical graduates, the MLA tests of applied knowledge and of clinical and professional skills will replace our current PLAB test. In addition, we hope that in future we will be allowed by law to test the knowledge and skills of EEA graduates through the MLA. But that will be subject to the outcome of the negotiations on the UK leaving the European Union.

Building on recent progress and pooling expertise

The introduction of the MLA would build on solid foundations and recent progress. Our PLAB test has been thoroughly revised. The medical schools have been working together through the Medical Schools Council Assessment Alliance (MSCAA) to develop a bank of examination questions and some common questions from this bank are now used each year in all medical schools' written finals. However, there are still significant differences between written finals at the medical schools and, in particular, they do not have a common standard to pass. The Medical Schools Council and the British Pharmacological Society have also developed a Prescribing Safety Assessment, which is taken by medical students and by doctors in the Foundation Programme who have not passed it previously.

There is growing recognition of the need to work together and pool expertise to create common arrangements to make sure a threshold for safe practice is achieved by doctors with a licence to practise. We intend to take this forward in a spirit of co-production with medical schools and others to deliver the best achievable Medical Licensing Assessment.

What does this consultation ask?

This consultation asks a number of fundamental questions about the MLA. At this stage, we're not seeking views on more detailed matters and on related questions which will be addressed once the more fundamental issues are resolved. At a later stage, we will consult on which types of overseas doctor could be exempted from the requirement to pass the MLA. We will also consider whether there might be any benefit in bringing forward the first revalidation date of doctors new to the medical register.

Focusing on a two-part assessment

In our early discussions about the MLA, we considered the possibility of a third part to the assessment. We described this as an early confirmation that the doctor is fit to hold a licence to practise on the UK medical register, and we thought this might take place around two years after they had first joined the medical register.

However, this option is best considered in the context of our arrangements for doctors' revalidation, which is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care. Sir Keith Pearson, Chair of our Revalidation Advisory Board, has recently completed an independent review of revalidation. His recommendations include that we should 'consider' setting an early revalidation date for newly-licensed doctors so that they receive their first revalidation date within two years of commencing practice in the UK. We will work with all our key interests, including those most closely involved in postgraduate training, to see whether there may be some merit in doing this for some cohorts of doctors. Also, we have commissioned a long-term evaluation of revalidation from the UK Medical Revalidation Collaboration (UMbRELLA) led by Plymouth University Peninsula Schools of Medicine and Dentistry. We will build on our arrangements for revalidation in light of the conclusions of Sir Keith's review and the UMbRELLA evaluation.

In that context we have decided to focus this consultation on the two conventional assessments that we believe should form the core of the MLA.

How do I take part?

There are 19 questions in the consultation document. You don't have to answer all of the questions if you prefer to focus on specific issues.

The consultation is open until 30 April 2017

You can answer the questions online on our consultation website or you can answer the questions using the text boxes in this consultation document and either email your completed response to us at mla@gmc-uk.org or post it to us at:

Education Policy team (MLA)
General Medical Council
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350 Euston Road
London
NW1 3JN

What happens next?

We will consider all the responses to the consultation and prepare a report on our findings. This report will be considered by our Council – our governing body – along with recommendations on the way ahead.

Subject to the outcome of this consultation and Council's view, we envisage developing detailed plans with experts and partners. We would then pilot the assessment extensively with a view to implementing the MLA fully in 2022.

What has led to this consultation?

The idea of a single MLA is not new. Licensing assessments or similar arrangements already exist in other countries including the United States and Canada. There are well-established UK-wide examinations in the various specialties for postgraduate medical training. And there are licensing assessments in the UK for other professions such as pharmacists.

In recent years, UK medical schools have recognised the challenge of having such a wide variation in the ways they assess students and they have started to work together more closely to develop shared questions to use in their finals. A Prescribing Safety Assessment is now taken by UK medical students and by doctors in the Foundation Programme who have not passed it previously. A UK-wide process has also been set up for selection into the Foundation Programme for new doctors after they leave medical school.

Meanwhile, the case for an MLA is growing given the decision to leave the European Union and the planned major expansion of medical school places, likely to be delivered in a variety of courses often run by new medical schools.

Work we've done to explore an MLA so far

In September 2014, the Council of the GMC (our governing body) agreed in principle to the idea of introducing a Medical Licensing Assessment and to develop proposals for how it could work. The Council approved an initial outline business case in June 2015. We've since worked closely with assessment and legal experts and with medical schools, other educational bodies and the four governments of the UK.

In particular, we visited all UK medical schools in early 2016. Discussions with their staff were very influential in developing the current plans and particularly the proposal to link MLA components with university finals. We have published a report on these discussions.

What is the aim of the MLA?

Aim

We have defined the aim of the MLA as:

'To create a single, objective demonstration that those applying for registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.'

Q1. Do you support the aim of the MLA?

☑ Yes ☐ No ☐ Not sure

Comments:

The College agrees that the aim of the MLA will help to ensure a uniform standard is applied and therefore assist in maintaining safe practice in the UK.

What is the scope of the MLA?

In light of the consultation, an early priority will be to identify the scope of the MLA and how it will assess the competencies required of doctors new to UK practice.

Key sources for developing the competencies to be tested by the MLA (set out in its blueprint) will include:

- *Good medical practice* and our other professional guidance
- our current *Outcomes for graduates* and *Outcomes for provisionally registered doctors with a licence to practise*
- our framework of generic professional capabilities
- evidence on the activities of Foundation Programme doctors
- the PLAB blueprint
- the blueprint for the question bank developed by the MSCAA.

We will make sure the MLA covers key aspects including:

- ethical and professional practice
- understanding the behaviours and systems that contribute to patient safety
- safe and effective prescribing
- UK clinical practice including cultural, legal and organisational factors, and both general practice and hospital-based settings.

However, there may be some competencies that are required of new doctors that are difficult or impossible to assess through an MLA using tests of applied knowledge and clinical and professional skills. Some competencies may be best addressed through forms of workplace-based assessment or appraisal once the doctors have started to practise, which might be linked to bringing forward the date of doctors' revalidation.

We'll need to make sure the content of the MLA is appropriate across all four countries of the UK.

The scope and the content of the MLA is likely to evolve over time. We'll need to define the starting point for the pilots and initial implementation, but the assessment will develop over the following years, not least to reflect changes in medical practice.

Medical schools will want to prepare their students for the MLA, so its blueprint must relate clearly to our requirements about undergraduate curricula in the *Outcomes for graduates*.

We will need to work closely with medical schools and others to review the outcomes to make sure they accurately reflect the competencies required of doctors entering practice.

Scope

The MLA blueprint will set out the knowledge and skills to be tested. It would draw on our *Outcomes for graduates*, taking account of the blueprints for the PLAB test and for the question bank developed by the MSCAA.

The MLA should test a wide range of competencies necessary for good doctors, including understanding patient safety, professionalism, ethics and the law relating to medical practice, prescribing and clinical practice in the UK.

Q2. What should we consider when defining the areas of knowledge and skill to be tested in the MLA?

Comments:

When considering the areas to be tested, the key criteria used should incorporate the skills and knowledge necessary for a doctor in varied everyday practice in the UK.

The main areas would therefore include medical knowledge; patient safety; prescribing; medical ethics and practical issues concerning the beginning of medical practice.

The framework for the MLA

We envisage a licensing assessment with two parts.

- Testing applied knowledge through multiple choice questions (MCQs).
- Testing clinical and professional skills through an objective structured clinical examination (OSCE).

Success in the MLA would be one of the requirements for UK medical students and international medical graduates to get registration with a licence to practise. We intend that the MLA will cover EEA graduates as well, allowing us to fulfil our long-standing ambition to check their competence before they practise in the UK, but that is subject to the outcome of the negotiations for the UK to leave the European Union. Also, we envisage that UK students would need to pass the MLA, as well as meeting assessment requirements set by their own university, to be awarded a degree that counts as a UK primary medical qualification.

We will need to define the assessment formats for piloting and initial implementation. The MLA will continue to develop over the years that follow.

The MLA would be UK-wide and must be capable of delivery in all four nations.

Test of applied knowledge

The test would:

- be a test of the application of medical knowledge
- use MCQs or similar arrangements in line with current best practice
- build on Part 1 of PLAB and on the bank of MCQs developed by the MSCAA
- be a computer-based test, delivered online and computer-marked, with scope for using sound and images
- initially involve a modified Angoff approach to standard setting to set the pass mark but informed by regular reviews using item response theory (IRT).

We envisage that for UK students, universities would include the test in their final exams, providing a core that medical schools would supplement to reflect their varied curricula. The process might build on the ‘common content’ approach of the MSCAA, whereby some questions from the bank appear in the final exams at all universities.

The number of questions would need to be sufficient to demonstrate the application of medical knowledge across the scope of the examination (the blueprint) at an appropriate level of reliability. It would need to involve central standard setting for the MLA content, as opposed to the universities setting their own pass marks. Universities would have flexibility on when their students would take the MLA MCQs to fit their curriculum.

We would also deliver a standalone version of the test for overseas doctors, with arrangements along the lines of the current PLAB Part 1.

We intend as soon as practicable to make use of the latest technical approaches but we may not be able to have these in place when the MLA is launched. For example:

- an IRT approach to standard-setting, using data to automatically generate the pass mark
- automatic generation of tests for local delivery on demand rather than on a limited number of dates over the year
- computerised adaptive testing to select additional questions to probe candidates and give more confidence in their scores.

Test of clinical and professional skills

The test would:

- be a test of clinical and professional skills
- involve an OSCE or similar simulated examination
- use the borderline regression approach to standard setting as part of a UK-wide approach to determining the pass mark
- reflect best practice at UK medical schools and medical royal colleges and faculties as well as the OSCE delivered by Part 2 of PLAB, recently enhanced
- involve trained medical examiners, simulated patients (actors or other role players), manikins and other forms of simulation
- involve standardised stations or scenarios and central determination of facilities and standards
- be available to fit with universities' varied curricula.

We envisage that UK medical students would take the MLA test of clinical and professional skills as part of their university finals. International medical graduates would need to pass the test as well as meeting our other requirements and taking the same approach to EEA

graduates, should this become possible, would allow us to check their competence before they can practise here.

In designing the test, we need to achieve the best combination of reliability, validity, affordability, practicality and impact on medical education. Options include:

Delivering the test at each UK university in existing facilities alongside a clinical assessment centre for overseas doctors.
The stations or scenarios would be standardised and there would be a UK-wide approach to determining the pass mark, but universities would be responsible for holding the test for their own students. We would need to explore how best to minimise variations in the MLA component but this approach could have logistical and cost advantages. In this context, we could consider whether it would be appropriate for some universities to embed the MLA stations in their own OSCEs, and for others to provide separate OSCEs for the MLA stations and for stations delivering their own assessments of clinical or professional skills.

Delivering the test at a limited number of clinical assessment centres across the UK – including each country in the UK.
In this option, we envisage centres in Northern Ireland, Scotland and Wales and say 3–6 centres in England. It might be possible to use existing premises at least in some cases, or new centres may need to be developed. Governance arrangements would need to be designed with the universities, consistent with their legal responsibility for holding finals including the MLA OSCEs. This option might have advantages – for example, in avoiding the expense of providing equipment at many sites. But it would involve some travel for the UK candidates and examiners.

We have ruled out a third theoretical option of providing all the tests for UK candidates and overseas doctors at one clinical assessment centre. This would be seriously unattractive in terms of the inconvenience and cost involved in travel for candidates and examiners. Also, under the current law, the arrangements would need to be consistent with the universities' responsibility to hold their finals including in future the MLA test of clinical and professional skills.

A hybrid and fluid approach is conceivable. For example, universities could choose whether to provide MLA OSCEs for their students or to team up with other universities in a joint approach.

We would aim to make use of the latest technology at the earliest opportunity. In particular, we aim to incorporate electronic marking that allows instantaneous data collection and analysis, preferably as part of the initial implementation of the MLA.

We are also interested in considering, as an element of the MLA OSCE, the approach used in the US Medical Licensing Examination (USMLE) where the candidates are assessed by standardised patients (trained actors) but with medical examiners marking notes made by the candidates on each case. Conversely, some aspects of professional practice might be

assessed through one-to-one professional conversations between candidates and medical examiners.

We could also explore the scope for a screening or sequential approach. This would involve creating an OSCE split into two sections. Most candidates would be able to demonstrate their competence through taking the first section alone, which would be relatively short, but candidates who perform less well would also be required to take the second section. This approach would reduce the test's length for most candidates, save resources and focus assessment where it is most needed, providing extensive testing of borderline candidates.

Framework

We propose an MLA of two parts in line with current best practice.

- Testing applied knowledge through multiple choice questions (MCQs).
- Testing clinical and professional skills through an objective structured clinical examination (OSCE).

Q3. Do you support this two-part framework?

☑ Yes ☐ No ☐ Not sure

Why?

The College supports this proposal as a two- part framework will test both factual knowledge and its application.

Test of applied knowledge

The MSCAA has developed a bank of MCQs. Each year, a selection of these questions is used in finals examinations across the UK. We have a separate bank of MCQs used in Part 1 of the PLAB test for international medical graduates.

Q4. Should the test of applied knowledge build on the banks of questions developed by the MSCAA and by the GMC for our PLAB test?

☑ Yes ☐ No ☐ Not sure

Comments:

The existing resource is suitable for use.

Test of clinical and professional skills

Currently, the clinical skills test for PLAB Part 2 is delivered at our clinical assessment centre in Manchester, while UK medical schools deliver a variety of clinical assessments of their students.

In deciding on the number of sites for the MLA test of clinical and professional skills, we'll consider various criteria including practicality, acceptability, reliability and cost.

Q5. For UK applicants, should the MLA test of clinical and professional skills be:

- **a** delivered at a limited number of sites across the UK, including all the UK countries
- **b** provided at each university separately, or
- **c** should each university decide whether to run the test for its own students or arrange for them to take the test elsewhere?

☐ a ☑ b ☐ c

Why?

A pragmatic approach should be taken to delivering the MLA test of clinical and professional skills: as mentioned in the document, university medical schools already deliver a range of clinical assessments and therefore should be the first option considered.

Q6. For overseas applicants, should the MLA test of clinical and professional skills be:

- **a** delivered at one UK site for all candidates
- **b** delivered at a limited number of sites across the UK, including all the UK countries
- **c** provided by UK universities recognised by the GMC to provide this service?

☐ a ☐ b ☑ c

Why?

Similar to the reasons mentioned in Q5, and this would also offer more flexibility to overseas applicants than only having the option of one UK site to attend.

The two MLA tests as components of university finals

We must avoid unnecessary duplication of assessment. We propose that the MLA tests of applied knowledge and of clinical and professional skills would provide an assessment core for UK university finals. Passing the MLA tests would be necessary but not sufficient for award of a UK primary medical qualification. The universities would include further material in their finals to reflect the diversity of their curricula.

Overseas doctors would need to hold an acceptable medical qualification before they could take the MLA tests or use other GMC mechanisms to demonstrate their knowledge and skills. They would also need to satisfy other requirements that we set to get registration with a licence to practise.

Q7. Do you agree that the MLA tests of applied knowledge and clinical and professional skills should be necessary but not sufficient components of university finals for UK candidates?

☑ Yes ☐ No ☐ Not sure

Why?

The timing and status of the MLA

To get registration with a licence to practise, UK graduates would need to hold a primary medical qualification encompassing success in the MLA and, as now, demonstrate their fitness to practise.

International medical graduates would, as now, need to hold a primary medical qualification that we deem acceptable. They would also need to pass the MLA unless they are pursuing alternative routes to registration and, as now, they would need to demonstrate their fitness to practise and knowledge of the English language.

It is also our ambition to apply the MLA to incoming EEA graduates. Doctors from Europe make a vital contribution to the health services across the UK and we do not expect that the decision to leave the EU will have any detrimental impact on the registration status of EEA qualified doctors already on the register. However, we have called for powers to allow us to check the clinical competence of incoming EEA graduates. Under current law, EEA graduates who want to register in the UK with a licence to practise need to hold an appropriate primary medical qualification and any supporting certification required by their country as set out in the European Directive on the mutual recognition of professional qualifications.[*] Under EU law, they are entitled to have their qualifications recognised and we could not require them to pass the MLA. We hope that the outcome of the negotiations on the UK leaving the European Union may allow us to require incoming EEA graduates to take the MLA.

Deciding the appropriate time to take the tests

The MLA tests of applied knowledge and clinical and professional skills could be taken at various points in the year. The medical schools will be able to identify the most appropriate point in their curricula. UK medical students would typically take the applied knowledge test in their penultimate year or early in their final year and then the test of clinical and professional skills at some point in their final year.

Setting the pass mark at the standard for full registration

The MLA is intended to create a single threshold for both UK medical students and overseas graduates. The standard to pass would be linked to demonstrating the knowledge and skills required for doctors with full registration. This is the level of competence currently required of international medical graduates taking the PLAB test and it would be a retrograde step to reduce our requirements for overseas doctors as a consequence of introducing a single threshold

[*] Directive 2005/36/EC on the mutual recognition of professional qualifications.

The Medical Schools Council and other bodies have considered whether provisional registration should be abolished, but that would require a change to the current legal position. We are not opposed to the abolition of provisional registration in principle, but it would be essential to avoid the risk to patients that could follow any lowering of the level of competence expected at the point of full registration. In particular, there could be real dangers if the minimum level of competence for international medical graduates is reduced from that required to pass the PLAB test. Introducing an MLA would allow us to make sure a common and defensible threshold is achieved by both UK graduates and overseas doctors.

It is not clear how challenging it would be for UK medical schools to prepare their students for an MLA with the pass mark set at the level currently required for full registration, whether or not provisional registration is abolished. We do not expect that this would create much difficulty in relation to the test of applied knowledge, but curricular reform might be necessary to make sure all UK students have the necessary clinical and professional skills. We will investigate this issue carefully through piloting to make sure appropriate pass marks are set for the MLA when it is introduced in 2022. Should provisional registration be abolished in the meantime, curricular reform may need to be considered and implemented with particular urgency.

Offering opportunity to resit the MLA

In the interest of fairness to applicants, it will be important to provide opportunity to resit the MLA, subject to a maximum number of attempts to be determined UK-wide. The criteria and arrangements will need to be agreed, including whether the resits will allow remediation or reflect mitigating circumstances or both, and may depend on how universities make the MLA available to their students. Perhaps resits could be held at a central clinical assessment centre.

Using data from the MLA

The MLA is intended to help us determine whether candidates should be granted registration with a licence to practise. Our provisional view, subject to this consultation, is that the MLA will not be designed to rank candidates for example, for selection into the Foundation Programme:

- as the regulator, we have no wish in principle to impose a particular selection system on the Foundation Programme
- the content of the MLA will be designed to determine who should and should not be licensed to practise, rather than to differentiate among candidates across the whole range of their competence
- if MLA scores were used for selection to the Foundation Programme, the tests would need to be taken considerably before completion of the undergraduate course

- to ease the integration of the MLA into finals, we envisage that the MLA tests will be taken at various points across the year, which could lead to concerns about whether candidates' scores are sufficiently comparable to support a robust and fair selection system.[*]

That said, we appreciate that some system of ranking is necessary for selection into the Foundation Programme and that MLA scores could provide useful information about candidates' competence. We are keen to hear views and collect evidence on whether MLA scores could contribute to selection into the Foundation Programme.

In any case, we expect to give candidates feedback on their performance in the MLA, including their overall scores and other examination data.

We will also analyse the data and make summary information available, which will allow medical schools to consider whether there is scope to improve the performance of their students. The data will also support our regulation of medical education and our tracking of medical careers. The data will be included in the UK Medical Education Database (UKMED) and available in non-identifiable form to approved researchers using the UKMED process. We would publish key information on our website, in line with our commitment to open regulation and sharing data where possible.

[*] For the 2017 Foundation Programme recruitment round, only two dates were available for candidates to sit the Situational Judgement Test, on 2 December 2016 and 9 January 2017.

The level of the MLA

The MLA will deliver assessment at a common threshold for UK students and overseas graduates. As with the current PLAB test for international medical graduates, the knowledge and skills will be assessed at the level required for full registration.

Q8. Do you think that by 2022, UK medical schools should be able to prepare their students for MLA tests of applied knowledge and of clinical and professional skills that have pass marks set at the level needed for full registration?

☐ Yes ☐ No ☑ Not sure

Why?

The College has significant concerns about the proposed level of the MLA. We would appreciate clarity over the intended level of the MLA, as a medical graduate is not of the same level as a trainee entering FY2. Is the MLA designed to be pre-clinical? The College is keen to ensure that standards are maintained to the highest levels, and our understanding of the proposals put forward suggest the achievement of a level of competence rather than excellence.

The status of the MLA

The MLA will be a licensing examination. Many of the candidates will also need to be ranked for selection into the Foundation Programme, but we see that as a separate matter based on other data.

Q9. Do you agree that the MLA should be used only to determine suitability for registration with a licence to practise and not to rank candidates for recruitment purposes?

☑ Yes ☐ No ☐ Not sure

Why?

The College agrees this should not be a grading exam for the purposes of recruitment.

Resitting the MLA

There will be opportunity for candidates to resit the MLA, but the number of attempts and precise arrangements need to be considered further.

Q10. Where MLA items are integrated into universities' written exams and OSCEs, should they expect their students to resit the whole assessment or should the candidates be able to take the standalone version of the relevant MLA test?

☐ Students should resit the whole assessment

☑ Students should resit a standalone version of the relevant MLA test

☐ Not sure

Comments:

Who will take the MLA?

In 2016, 7,177 graduates from UK medical schools were registered along with 2,166 EEA graduates. In addition, 1,589 international medical graduates, with medical degrees obtained outside Europe, were registered having passed the PLAB exam and 1,839 through other routes to registration. Also in 2016, 3,141 international medical graduate candidates took the PLAB Part 1 test and 2,268 took Part 2.

We envisage that all UK graduates would need to pass the MLA to get registration with a licence to practise and passes in the MLA tests would also be necessary, but not sufficient, to get a primary medical qualification.

Passing the PLAB test is one way in which international medical graduates can get registration with a licence to practise. Other ways currently include:

- sponsorship by an organisation we recognise – 690 doctors registered through this route in 2016
- holding a postgraduate qualification that we deem acceptable – 808 doctors registered through this route in 2016
- joining the Specialist Register or GP Register by the doctors demonstrating that their competence is at least equivalent to the standard we require for candidates completing UK specialty/GP training – ten doctors registered through this route in 2016
- temporary registration – 48 doctors registered through this route in 2016.*

In addition, there is a strong case to create a separate mechanism for senior doctors who want to practise in the UK but who cannot realistically take the PLAB test (or in future the MLA) or use one of the other routes to registration. There is a current legal arrangement which allows the temporary registration of eminent specialists but this restricts them to 26 weeks' registration in any five year period. However, this restrictive arrangement does not provide an appropriate route to registration for senior doctors to contribute their expertise and experience to health care in the UK.

Reviewing the current PLAB exemptions

Exemptions to the MLA will need to be considered in light of its aim, which is to create a single, objective demonstration that those applying for registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.

* The figures relate to doctors joining the medical register for the first time in 2016. The figure for temporary registration includes EEA graduates as well as international medical graduates.

However, the current exemptions from the PLAB test for international medical graduates reflect the range of their skills and expertise, our reliance on the supporting systems and evidence, and the doctors' intended roles in the UK. We have no wish to erect unnecessary barriers to good doctors coming to practise in the UK, particularly given the current shortages in some specialties and the importance of international collaboration in medical science, research and technology. We are not attracted to the approach in the USA where all but a few incoming doctors are required to take their licensing examination.

Clearly we will need to set out clear rules on the exemptions that will apply to the requirement to pass the MLA, which we hope will apply to EEA graduates as well as international medical graduates from the rest of the world. Before introducing the MLA we will therefore review the exemptions that currently apply to the PLAB test and work up options with the medical royal colleges and faculties, universities and medical schools, research councils and other organisations involved. We will then publish proposals for consultation. The review might focus on the importance of patient safety and public confidence and possibly draw distinctions between new medical graduates, doctors fairly new to practice, well-established doctors and particularly-eminent doctors.

We are largely free to determine the exemptions from the MLA but some changes, eg in relation to eminent specialists, would require statutory change and so could take longer to implement. At this stage, we would welcome views in principle on the extent to which exemptions should apply to the MLA.

EEA graduates and information on the medical register

Our ambition is to include EEA medical graduates in the MLA in a manner consistent with our approach for other doctors entering UK practice. We envisage in any case that some EEA graduates will choose to take the MLA as an international mark of quality to demonstrate their level of knowledge and skill. In our separate consultation on developing our online register, we proposed that the medical register might include information on completion of the MLA.

Bringing forward doctors' first revalidation

We have also been considering whether it would be advantageous to bring forward doctors' first revalidation. This could, for example, help to make sure newly registered doctors' learning and development needs are identified early and would help to protect patients.

We could look further into this option, in the context of building on our current arrangements for revalidation. Sir Keith Pearson, Chair of our Revalidation Advisory Board, recently completed an independent review of revalidation. His recommendations include that we should consider setting an earlier revalidation date for newly-licensed doctors, so they receive their first revalidation date within two years of beginning practice in the UK.

We work with all our key interests, including those most closely involved in postgraduate training, to see whether there may be some merit in doing this for some cohorts of doctors. Also, we have commissioned a long-term evaluation from the UK Medical Revalidation Collaboration (UMbRELLA) led by Plymouth University Peninsula Schools of Medicine and Dentistry.

Exemptions to the MLA

In 2016, 1,589 international medical graduates with degrees obtained outside Europe gained registration by taking our PLAB test. 1,839 international medical graduates used other ways to register, exempting them from the PLAB test.

Exemptions from the MLA would need to be considered in light of its aim to create a single, objective demonstration that those applying for registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.

But we have no wish to erect unnecessary barriers to good doctors coming to practise in the UK, particularly given the current shortages in some specialties. We will review the current exemptions and consult separately on this issue before introducing the MLA.

Q11. Do you think the exemptions from the MLA should be more or less extensive than those that currently apply to the PLAB test?

☐ More extensive ☐ Less extensive ☑ Much the same ☐ Not sure

Comments:

Paying for the MLA

The cost of the MLA will be subject to decisions on its format and delivery, which will be made in light of the feedback we receive through this consultation. We expect that the GMC will bear the development costs of creating a world class assessment, but we also need to consider how the ongoing costs would be met.

Under our proposals, the MLA for overseas candidates would be funded through their fees while the cost for UK candidates would be met by the GMC and by the medical schools, since they run the finals that would include the MLA tests.

The running cost of the tests of applied knowledge and of clinical and professional skills will depend largely on how they are linked with university finals for UK graduates, bearing in mind that similar tests are already delivered at every medical school. But even in relation to the standalone delivery of these tests for overseas doctors, there are various options set out in this consultation document with distinct resource implications.

In fixing the charges that we levy for various GMC activities, we follow three principles.

1 We have various statutory powers to levy fees to recover our costs and must exercise these powers to make sure we remain a going concern.

2 Activities that benefit the majority of doctors should be funded through the annual retention fee (ARF), the annual fee paid by doctors to stay registered.

3 Discrete activities that benefit specific cohorts of doctors (including those who are not currently registered with us) should be funded by those doctors through separate fees. Those fees should cover the full costs of those activities, to avoid cross-subsidy from the ARF.

We have no intention of seeking financial support for the MLA from the health services, other employers of doctors or the four governments of the UK.

Any arrangements to charge candidates to take the MLA must be fair and equitable for all candidates. We suggest that it would be inappropriate to charge UK students to take MLA tests which are taken as necessary (not sufficient) components of their university finals. Currently, the PLAB test is funded through fees paid by the candidates with limited specific arrangements for refugee doctors. These fees and arrangements could continue for overseas doctors taking the MLA.

We envisage that universities will contribute to the running costs of the MLA in relation to the assessment of their students as part of their finals. However, linking MLA tests with university finals could create economies of scale and pool expertise. Also, the MLA could support a more focused approach to our quality assurance of medical education, potentially reducing the regulatory burden for many schools.

So the MLA could involve a combination of additional costs and savings for the universities as well as new central costs. Indeed, the introduction of the MLA could involve the GMC funding investment in the infrastructure of medical schools – for example, in relation to simulation equipment, which would then be available for the schools' internal assessments as well as for teaching.

Who would pay for the MLA?

The cost of the MLA will be subject to decisions on its format and delivery, which will be made in light of the feedback we receive through this consultation.

We expect that the GMC will bear the development costs of creating a world class assessment, but we also need to consider how the ongoing costs would be met.

Under our proposals, the MLA for overseas candidates would be funded through their fees while the cost for UK candidates would be met by the GMC and by the medical schools, since they run the finals that would include the MLA tests.

Q12. For UK candidates, should the cost of the MLA be met by the GMC and the medical schools?

☑ Yes ☐ No ☐ Not sure

Why?

Q13. For overseas candidates, should the cost of the MLA be funded through fees to take the tests?

☑ Yes ☐ No ☐ Not sure

Why?

Governance and review

The MLA would be an arm of medical regulation and so come under our remit. This will make sure entrants to the medical register with a licence to practise demonstrate through the assessment that they have met the threshold that we require. It will also relate to our role in regulating medical education and provide information to support quality assurance of the UK medical schools.

However, it will be essential for the MLA to be developed and run in collaboration with partner organisations, such as medical schools, foundation schools, employers, the four UK governments and bodies representing the profession, as well as patients and the public. We have already set up an expert reference group and propose to establish a programme board at arm's length from ourselves, but accountable to us, with functions and powers to be decided.

To give an external review of the MLA, we propose to commission an independent annual analysis. In addition, we could commission an external body to quality assure the MLA.

Governance and review

We will need thorough governance and review processes for the MLA.

Q14. Do you support our proposal for a programme board at arm's length from, but accountable to, the GMC?

☑ Yes ☐ No ☐ Not sure

Why?

Introducing the MLA

Introduction of the MLA by 2022 will be a major programme of work for us – see the indicative outline implementation plan at annex B.

We would not need changes in the *Medical Act 1983* to replace the PLAB test with the MLA or to require university finals to include the MLA tests. However, we would not wish to proceed without support in principle at government level across the four nations of the UK.

Under the current arrangements, we would also discuss our proposals with the European Commission. The UK's decision to leave the European Union could have substantial implications for EEA graduates hoping to work in the UK and lead to our requiring them to take the MLA.

The UK medical schools will need to review and potentially revise their curricula and assessment arrangements in light of our review of the *Outcomes for graduates* that we mandate as well as our preparation of the blueprint and formats for the MLA in collaboration with medical schools. The period up to 2022 should give sufficient time to prepare. Including the MLA tests in finals may also involve some changes to universities' systems and rules.

Developing the MLA will require significant involvement by assessment experts from medical schools.

Significant engagement and commitment will also be needed from partner organisations and constituencies across the four UK countries as the blueprint is developed and all key interests take this work forward.

Introducing the MLA

We plan to complete the consultation and analyse the responses in 2017. In light of that feedback, and working with the four UK governments, medical schools and other partners, we will then need to review the *Outcomes for graduates*, determine the assessment formats, develop the blueprint and build up the necessary infrastructure. We will need a programme of extensive piloting and plan to implement the MLA fully from 2022.

Q15. Is the proposed timeline:

- **appropriate**
- **overly ambitious**
- **too protracted?**

☐ Appropriate ☑ Overly ambitious ☐ Too protracted ☐ Not sure

Why?

The College has concerns that the proposed timeline would mean there are some students already in medical school who would be affected by the introduction of the MLA. A longer timeline would be preferable to ensure the process is fit for purpose prior to introduction.

Impact and comment

Working with the medical schools, we will need to work up more specific arrangements for linking the MLA tests with university finals. Medical schools will still be responsible for making sure primary medical qualifications are awarded only to students who are fit to practise and meet our *Outcomes for graduates*. They will also remain responsible for holding examinations for the purpose of granting primary medical qualifications.

Considering equality and diversity

We will need to consider the impact of the MLA from the perspective of equality and diversity and the differential attainment of categories of candidates. Clearly, the MLA must be fair and non-discriminatory. We have started work on an equality analysis and this will be developed as we refine and firm up our plans for the MLA.

Making sure the MLA doesn't distort medical school curricula

There have been some concerns expressed that the MLA might undermine curricular diversity. The proposed way forward is designed to prevent this – medical schools will vary in their approach to helping students meet the outcomes assessed in the MLA and they will also be expected to include other material in their curricula, which they will be responsible for assessing.

Given that assessment drives learning, there is concern that a new high-stakes assessment could distort the delivery of curricula if students focus on cramming for the MLA. However, students will understand that passing the MLA is necessary but not sufficient for award of a primary medical qualification and that they will also need to pass the university's components of finals. Giving universities choice in the timing of the MLA tests will limit the impact on students' commitment to clinical placements. In any case, performance in the test of clinical and professional skills will be determined largely by learning from clinical practice rather than textbook cramming.

There is also concern that the MLA could increase the assessment burden on medical students. Integrating the MLA into finals is intended to avoid this and medical schools will not wish to duplicate the MLA elements of finals with additional home-grown assessments that cover the same ground in a similar manner. In light of the responses to this consultation, we will be working closely with experts from medical schools, royal colleges and faculties and other organisations to identify the best possible form of integration into finals.

We will commission research into the impact of the MLA and how to maximise its beneficial effects and keep to a minimum any potential disadvantages.

Impact

We will need to evaluate the impact of the MLA and take this into account as we develop arrangements over time. This includes the impact on people in relation to their 'protected characteristics' as identified in the *Equality Act 2010*.*

Q16. What, if any, impact might the MLA have on doctors with particular protected characteristics?

Comments:

None

Q17. How can we best evaluate the more general impact of the MLA?

Comments:

Assessing the percentage of resits will help to evaluate this.

* Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Achieving the aim

We believe that our plans for introducing the MLA will meet our aim to create a single, objective demonstration that those applying for registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.

Q18. Do you agree that our plans will meet the aim to create a single, objective demonstration that those applying for registration with a licence to practise medicine in the UK can meet a common threshold for safe practice?

☐ Yes ☐ No ☑ Not sure

If not:

a in what respects will our plans fall short of achieving the aim?

b what should we do instead?

a:

b:

Further comments

Introduction of the MLA will be a substantial change in UK medical regulation and education. We would welcome your comments on the opportunities and challenges we could face.

Q19. Do you have any other comments on our proposals and on how our aim could best be achieved?

This is an important opportunity to standardise the skill set, and the College would appreciate clarity on the level of the MLA to ensure that this aim can be achieved.

Annex A – benefits from the MLA

The central benefit envisaged from the MLA is to secure the aim:

> *To create a single, objective demonstration that those applying for registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.*

More specifically, the MLA would bring benefits to patients, doctors already practising in the UK, doctors' employers, medical schools and also the UK medical students and overseas doctors wishing to practise in the UK.

- It supports soundly based confidence in and respect for new doctors among their patients, colleagues and employers, no matter where the doctors were educated or trained, thereby enhancing the high reputation of the medical profession in the UK.
- It allows a clear and common understanding of the level and extent of the knowledge and skills required of new doctors.
- It makes sure new doctors have the knowledge and skills necessary for full registration, in addition to the existing requirement to demonstrate experience in a period of supervised practice.
- It lets us address healthcare needs and enhance patients' safety and experience by responding to evidence on shortfalls in the competence of new doctors as well as demographic and other changes that affect the sort of care that patients need.
- It lets us raise the threshold for entry to the profession over time to enhance good medical practice.
- It gives a benchmark and an incentive for medical schools to drive up the quality of the education and training they provide.
- It could free up resources for medical schools, by pooling assessment expertise, achieving economies of scale and drawing in investment from the GMC.
- It creates a marker of the excellence of UK medical education and practice.
- It is demonstrably fair to candidates whichever medical school they attended and whether they come from the UK, Europe or the rest of the world.
- It secures the importance of curricular diversity beyond the MLA assessment core.
- It introduces assessment designed in co-production with medical schools, by leading UK assessment experts and drawing on international best practice.

- It gives a new regulatory tool to secure the quality of UK medical education in a period of expansion and increasing variety of provision.
- It creates a new foundation of evidence to track the careers of UK doctors, allowing us to better understand the barriers to success and the factors contributing to risks, so we can more effectively intervene to promote both fairness in training and patients' safety and experience.

Annex B – indicative outline implementation plan

This table summarises our current intentions and important tasks that would need to be completed to implement the MLA fully in 2022. Our full implementation plan will be developed and kept under review, particularly in light of responses to the consultation.

2017	Completion of the consultation and analysis of the response Support in principle secured from the four UK governments, UK medical schools and other key stakeholders Policy decisions by the Council of the GMC in light of the consultation response and other evidence and advice Development of MLA blueprint and review of the *Outcomes for graduates*
2018–21	Definition of MLA test formats Agreement on examination rules, procedures and policies GMC and medical school infrastructure development Recruitment and training of question/item writers, standard setters, examiners and role players Development of the item bank of multiple choice questions and OSCE stations Rounds of piloting of MLA test formats and approaches for their delivery Review of undergraduate curricula by medical schools and review of the Foundation Programme curriculum Changes to university systems and rules to include the MLA tests in finals
2022	Implementation of MLA tests for both UK students and overseas doctors seeking registration with a licence to practise
2023	Initial evaluation of impact

Annex C – glossary of abbreviations and terms

Angoff method – a method of standard setting based on group judgments about the performance of hypothetical borderline ('just passing') doctors in training.

ARF – the annual retention fee, the fee doctors pay to keep their name on the medical register (the GMC's List of Registered Medical Practitioners).

CAT – computerised adaptive testing, a form of computer-based testing that adapts to the examinee's ability level.

IRT – item response theory, an approach to the design, analysis and scoring of tests and similar approaches to measuring competencies or other variables.

MCQ – multiple choice question, a question format commonly used in examinations.

MSC – the Medical Schools Council, which represents the interests and ambitions of UK medical schools.

MSCAA – the Medical Schools Council Assessment Alliance, a partnership to improve undergraduate assessment practice through collaboration between the UK medical schools.

OSCE – objective structured clinical examination, an assessment format involving a circuit of short stations where candidates demonstrate clinical and professional skills.

PLAB test – the Professional and Linguistic Assessments Board test, by which many international medical graduates demonstrate that they have the necessary skills and knowledge to practise medicine in the UK.

Reliability – in relation to assessments, an expression of internal consistency and reproducibility.

Summative assessments – assessments set against a standard or benchmark, the results of which determine a student's progress in or completion of a course.

UKMED – the UK Medical Education Database, which brings together undergraduate and postgraduate data relating to UK medical education.

Validity – in relation to assessments, the degree to which a measurement instrument truly measures what it is supposed to measure.

About you

Finally, we'd appreciate it if you would please give some information about yourself to help us analyse the consultation responses.

Your details

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Would you like to be contacted about our future consultations?

☑ Yes ☐ No

If you would like to know about upcoming GMC consultations, please let us know which of the areas of the GMC's work interest you:

☑ Education ☑ Standards and ethics ☑ Fitness to practise

☑ Registration ☑ Licensing and revalidation

Data protection

The information you supply will be stored and processed by the GMC in accordance with the *Data Protection Act 1998* and will be used to analyse the consultation responses, check the analysis is fair and accurate, and help us to consult more effectively in the future. Any reports published using this information will not contain any personally identifiable information. We may provide anonymised responses to the consultation to third parties for quality assurance or approved research projects on request.

The information you provide in your response may be subject to disclosure under the *Freedom of Information Act 2000* which allows public access to information held by the GMC. This does not necessarily mean that your response will be made available to the public as there are exemptions relating to information provided in confidence and information to which the *Data Protection Act 1998* applies. You may request confidentiality by ticking the box provided below. Please tick if you want us to treat your response as confidential.

☐

Responding as an individual

Are you are responding as an individual?

☐ Yes ☑ No

If yes, please complete the following questions. **If not, please complete the 'responding as an organisation' section on page 47.**

Which of the following categories best describes you?

☐ Doctor ☐ Medical educator (teaching, delivering or administering)

☐ Medical student ☐ Member of the public

☐ Other healthcare professional

☐ Other (please give details) _____

Doctors

For the purposes of analysis, it would be helpful for us to know a bit more about the doctors who respond to the consultation. If you are responding as an individual doctor, would you please tick the box below that most closely reflects your role?

☐ General practitioner ☐ Consultant

☐ Other hospital doctor ☐ Trainee doctor

☐ Medical director ☐ Other medical manager

☐ Staff and associate grade (SAS) doctor

☐ Sessional or locum doctor ☐ Medical student

☐ Other (please give details)_____

If you are a doctor, do you work ☐ full time? ☐ part time?

What is your country of residence?

☐ England ☐ Northern Ireland ☐ Scotland ☐ Wales

☐ Other – European Economic Area

☐ Other – rest of the world (please say where) _____

Would you be happy for your comments in this consultation to be identified and attributed to you in the reporting?

- [ ] Happy for my comments to be attributed to me
- [ ] Please keep my responses anonymous

To help ensure that our consultations reflect the views of the diverse UK population, we aim to monitor the types of responses we receive to each consultation and over a series of consultations. Although we will use this information in the analysis of the consultation response, it will not be linked to your response in the reporting process.

What is your age?

- [ ] Under 25
- [ ] 25–34
- [ ] 35–44
- [ ] 45–54
- [ ] 55–64
- [ ] 65 or over

Are you:

- [ ] Female
- [ ] Male

Would you describe yourself as having a disability?

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

The *Equality Act 2010* defines a person as disabled if they have a physical or mental impairment, which has a substantial and long-term (ie has lasted or is expected to last at least 12 months) and adverse effect on the person's ability to carry out normal day-to-day activities.

What is your ethnic group? (Please tick one)

White

- ☐ English, Welsh, Scottish, Northern Irish or British
- ☐ Irish ☐ Gypsy or Irish traveller
- ☐ Any other white background, please specify _____

Mixed or multiple ethnic groups

- ☐ White and black Caribbean ☐ White and black African ☐ White and Asian
- ☐ Any other mixed or multiple ethnic background, please specify _____

Asian or Asian British

- ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
- ☐ Any other Asian background, please specify _____

Black, African, Caribbean or black British

- ☐ Caribbean ☐ African
- ☐ Any other black, African or Caribbean background, please specify_____

Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group, please specify _____

Responding as an organisation

Are you responding on behalf of an organisation?

- [x] Yes
- [ ] No

If yes, please complete the following questions. **If not, please complete the 'responding as an individual' section on page 44.**

Which of the following categories best describes your organisation?

- [ ] Body representing doctors
- [ ] Body representing patients or public
- [ ] Government department
- [ ] Independent healthcare provider
- [ ] Medical school (undergraduate)
- [x] Postgraduate medical institution
- [ ] NHS/HSC organisation
- [ ] Regulatory body
- [ ] Other (please give details) _____

In which country is your organisation based?

- [x] UK wide
- [ ] England
- [ ] Scotland
- [ ] Northern Ireland
- [ ] Wales
- [ ] Other (European Economic Area)
- [ ] Other (rest of the world)

Would you be happy for your comments in this consultation to be identified and attributed to your organisation in the reporting?

- [x] Happy for comments to be attributed to my organisation
- [ ] Please keep my responses anonymous

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