The Royal College of Ophthalmologists' (RCOphth) response to the General Medical Council's consultation on introducing a Medical Licensing Assessment

28 April 2017

Introduction

The Royal College of Ophthalmologists welcomes the opportunity to respond to this consultation.

The RCOphth is the professional body for ophthalmologists and we champion excellence in the practice of ophthalmology on behalf of our members to optimise care for patients. We set the curriculum and examinations for trainee ophthalmologists, provide training in eye surgery and work with leaders across the eye health sector to maintain standards in the teaching and practice of ophthalmology.

Overall Comments

Overall we support the GMC's case for introducing a common threshold for all doctors entering UK practice.

It is essential to ensure that all candidates for the UK medical register, whether from the UK, EEA or further afield, have the necessary level of competence to practice safely and effectively. This is important given the increasing variation in quality of UK and overseas medical graduates.

We agree that the GMC's proposed medical licensing assessment (MLA) has the potential to be an effective way to ensure a common standard among candidates. Our primary concern is that candidates for registration are sufficiently prepared for practice in the UK, based on current patient needs.

We have set out below several points we feel are important to consider to ensure that the proposed changes are fit for purpose.

Q1. Do you support the aim of the MLA?

Yes, we support the aim of the MLA and consider that it has the potential to ensure a common base-line standard for all doctors working in the UK.

We consider it important to ensure that the MLA should apply fairly to UK, EEA and overseas candidates. We would be concerned if the MLA was introduced without some

guarantee that it would apply across all groups, especially before the terms of Brexit have been finalised.

We would underline the importance of considering any potential barriers to the appointment of highly competent senior clinicians from overseas to specialist posts (e.g. professors of Medicine), that may be created by insisting that they take a medical school graduating examination. We have expanded on this point under question 11 on exemptions.

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

We agree that the MLA should clearly relate to the Outcomes for graduates. We consider this document provides a good basis for defining the knowledge and skills required of a newly qualified doctor.

However, we have significant concerns about a lack of knowledge and skills in ophthalmology among UK graduates and highlight that the Outcomes should reflect the areas of competence required for practice.

A survey we carried out in 2014 of around 900 senior medical students and foundation doctors, found that half lacked the ability to confidently diagnose and treat common ophthalmic conditions.

Ophthalmic assessment is an essential part of identifying many systemic diseases, such as diabetes and hypertension. Eye problems account for 1.5% of consultations in general practice and are common in emergency and acute medicine.

Therefore, although small numbers will specialise in ophthalmology, having basic ophthalmic assessment skills is essential for all graduates.

The introduction of the MLA provides an opportunity to address the gap between current practice requirements and undergraduate training. Therefore, we urge the GMC to ensure that the MLA adequately covers ophthalmology, and that the Outcomes framework include clearer and stronger requirements relating to eyes and vision.

We also encourage medical schools to make use of our “Eyes & Vision Curriculum” for Undergraduate and Foundation Doctors when reviewing their teaching content.

Finally, we consider the following areas of knowledge and skills essential for all graduates.

- The ability to communicate effectively with patients, carers and other health and care professionals.

- Knowledge of medical and surgical principles related to the practice of Medicine in the UK, including a working knowledge of the common and important rarer disorders of the population of the UK, their diagnosis and modern management.

- An understanding of the workings of the NHS to include the community services, eye care services such as optometry, and dentistry.

Q3. Do you support this two-part framework?

Yes, we support the proposed two-part framework.

We consider this proposal a good way to ensure a high level of both academic study and practical competence.

OSCEs are essential to ensure that the practitioner can communicate effectively, examine patients and come to a logical diagnosis. However, we strongly urge the use of real patients rather than 'standardised' actor patients. Eliciting signs from real patients is a much more effective way of assessing clinical skills.

We also have concerns about how sufficient medical examiners for the MLA will be recruited and supported. Given the significant pressures Consultants and GPs are already under to deliver services, they face considerable difficulty in obtaining time away from clinics and surgery. Therefore, we would welcome further information on this issue and an opportunity to discuss it with the GMC.

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, on the basis that questions have already been validated and will be updated as appropriate.

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?

Why?

Each university, because participation of real patients in the OSCEs would be easiest to arrange at individual medical schools.

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?

Why?

UK universities because participation of real patients in the OSCEs would be easiest to arrange at individual medical schools.

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?

Not sure.

We would support greater standardisation of curricula and assessment in order to effectively prepare students for the common MLA. This would also ensure that all areas of practice, such as ophthalmology are sufficiently covered during teaching.

We also recognise the value of preserving a degree of variation in teaching methods and areas of specialism between universities, on the basis that there is sufficient consistency to ensure all graduates are prepared for registered practice.

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?

Not sure.

A single point of registration would allow standardisation with doctors from overseas. It would also give UK medical students a clear idea of the standard that they have achieved when they qualify.

However, careful consideration must be given to the implications of bringing forward full registration. Full registration may imply a greater level of competence than provisional registration, and therefore ability to take greater responsibility. Any change in expectations and responsibilities placed on new graduates, must not outstrip their level of competence.

Therefore, we would welcome further clarity on the possible implications of this proposed change, especially how patient safety and trainee support will be ensured.

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?

Not sure. The MLA could be considered a ‘minimum standard required’ assessment which would be unsuitable for ranking.

However, it is possible that if a separate ranking system was also used, a medical student could potentially fail the MLA but rank highly on the alternative system. Ideally the MLA, as a national exam fit for all, would underpin both registration and ranking processes, with ranking going beyond baseline assessment.

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:

We feel that students should re-sit only the part that they failed, whether a standalone version of the MLA or just the relevant material from within the MLA component.

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:

We support the suggestion of distinguishing between new graduates, established and eminent doctors in order to provide an appropriate system of exemptions. We would welcome the opportunity to work with the GMC to develop this. Fellows often have several years of experience within ophthalmology before coming to the UK for a specialist post, therefore we would not consider it appropriate to require them to pass assessments in general medicine and surgery in order to practice.

It would be useful to consider how well doctors who entered via the PLAB have performed as clinicians compared to those who were exempt.

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

Yes. We consider it would be inappropriate to add another financial burden onto the already costly process of training as a doctor in some parts of the UK. However, it may be appropriate to apply a fee to candidates whose training has been subsidised by a local government, such as in Scotland.

We support the concept of incorporating the MLA into existing Finals to minimise additional costs.

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

Not sure.

Fees should not be passed on to UK doctors.

This proposal is in line with other countries who charge licensing examination fees for overseas candidates.

There is also a case for the NHS or government paying for such tests as they would not have contributed to the cost of undergraduate medical education of overseas candidates.

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

Yes. This must be independent of the body that sets the MLA process standards.

Q15. Is the proposed timeline:

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

We feel this to be a reasonable target, if there is sufficient interest in establishing the MLA it should be possible to deliver it in this time frame.

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

We do not consider there should be any reason that any group would be adversely affected if reasonable adjustments are provided as appropriate.

The issue may be relevant to doctors who passed the PLAB some years ago, and have now developed a disability that renders them disadvantaged to take the MLA.

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

Collecting accurate performance data on existing trainees and determining whether PLAB doctors, for example, perform as well as UK trained doctors. If not, this may indicate a poorer standard at qualification, and strengthen the case for a MLA.

We also suggest conducting surveys of:

- the Doctors responsible for the new “MLA-approved” FY1 cohort;

- the new MLA- approved cohort; and

- the public who use NHS services. There have been anecdotal reports of difficulties in communication from patients who are cared for by doctors from non-English speaking countries.

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?