Witness Name: Charles Hamilton Massey

Statement No.: 1

Exhibits: CM/1 - INQ000362199 to CM/34 - INQ00037743

Dated: 30 January 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF MR CHARLES HAMILTON MASSEY

I, Charles Hamilton Massey, of the General Medical Council, 3 Hardman Street, Manchester, M3 3AW, will say as follows: -

1. My name is Charles Hamilton Massey. I am the Chief Executive and Registrar of the General Medical Council ('the GMC'), and I have held this role since 1 November 2016.

2. I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 9 June 2023.

3. This is my first witness statement for the UK Covid-19 Inquiry ('the Inquiry').

About the GMC and our response to the Inquiry

4. The GMC is the regulator of doctors and will regulate physician associates and anaesthesia associates towards the end of 2024. We are an independent organisation that helps to protect patients and improve medical education and practice across the UK.
    a. We decide which doctors are qualified to work here and we oversee UK medical education and training.
    b. We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.

c. We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

5. The GMC is independent of government and the medical profession and we are accountable to Parliament. Our powers are given to us by Parliament through the Medical Act 1983 ('the Act').

6. The Covid-19 pandemic placed unprecedented stress on the UK healthcare systems and the healthcare professionals that work in and run them. We recognise the instrumental role that doctors played to support the system and protect the lives of their patients. The pandemic required many doctors to work in circumstances that were unfamiliar, complex, and outside of their usual scope of practice, and we want to thank doctors for their contribution during the pandemic and for continuing to help the systems recover. We also remember the doctors and other healthcare professionals who sadly lost their lives during the pandemic.

7. We welcome the opportunity to contribute information to the Inquiry. This statement sets out how we rapidly adapted our regulatory approach to ensure that we were able to continue to prioritise patient safety, as well as supporting doctors and the wider UK healthcare system to respond to the pandemic. This included:

    a. **Section one:** contributing to increasing the capacity of the UK healthcare system, whilst ensuring a continued focus on patient safety, through:
        - changing our arrangements for registering doctors so that more of them could take up frontline practice;
        - expediting the provisional registration process for graduates from UK medical schools, so that they could begin frontline practice earlier;
        - adapting our revalidation, education and training, and fitness to practise processes to support the wider healthcare system to prioritise frontline care in exceptionally challenging circumstances.
    b. **Section two:** supporting doctors facing challenging situations by advising on the application of our standards and guidance in the specific context of the pandemic.
    c. **Section three:** collaborating with other regulators and system partners across all four countries of the UK to ensure clear and consistent advice, guidance and messaging for doctors, other healthcare professionals and patients in uniquely challenging circumstances.

d. **Section four:** our learning from the pandemic and resulting recommendations for arrangements in future healthcare emergencies for the Inquiry's consideration.

Section one: Contributing to the capacity of the healthcare system to respond to the pandemic by increasing the number of licensed doctors who could take up frontline practice

Granting temporary emergency registration

8. The GMC holds the register of medical practitioners who are eligible to practise in the UK. To practise medicine in the UK a doctor must be both registered with the GMC and hold a licence to practise.[1] In 2024, there are over 300,000 doctors on the UK medical register, most of whom hold a licence.
9. On 1 March 2020, there were a total of 261,450 doctors with a licence to practise in the UK. We have attached more information on the number of doctors with a licence to practise, by country and speciality. This can be found at exhibit one [CM/1 - INQ000362199].
10. In early March 2020, as the need to increase medical capacity to support the pandemic response became clear, we rapidly engaged with the four UK Chief Medical Officers (CMOs) to agree what our approach would be to temporary emergency registration (TER) in the event that our emergency powers under Section 18A of the Act were activated. The emergency powers allow us to register anyone who we consider is a *'fit and proper and suitably qualified person… with regard to an emergency.'*[2]
11. Following our discussions, we wrote to approximately 15,000 doctors with a UK address who had left the register or given up their licence to practise after March 2017. We informed them that we expected our emergency powers would be activated and that, in this event, they would be granted TER. As this cohort was

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[1] Doctors who practise medicine in the UK need to hold a licence to practise along with the suitable type of registration for the work that they do. It is the licence to practise which allows them to carry out certain activities such as prescribing medicines and treating patients.
[2] Section 18A(1)(a) of the Act.

contacted before our emergency powers were activated, doctors were able to tell us they did not want TER before it was granted.

12. Our emergency powers can be used when the Secretary of State for Health and Social Care advises the Registrar of the GMC that an emergency[3] has occurred, is occurring or is about to occur. Such emergencies are not limited to pandemics.

13. Our emergency powers were activated on 25 March 2020 when the GMC received correspondence from the then Secretary of State, the Rt Hon Matt Hancock MP, to advise that action should be considered under the provisions of this section.

14. Between 26 March and 3 April 2020, we granted TER to 34,837[4] fully qualified doctors with a UK address. This figure includes doctors who had left the register after March 2014 and before March 2017 (6,800), after March 2017 (15,467), or who were still registered with us but did not have a licence to practise (12,190). We did this in stages. A full breakdown of the stages can be found at exhibit two [CM/2 - INQ000362206].

15. We emailed these doctors to confirm that we had granted them TER or a temporary emergency licence to practise, which meant they could return to practise to support the pandemic response, should they wish to do so.

16. On 25 January 2021 we contacted a further 2,533 eligible doctors who had left the register since March 2020 to offer them TER. While we did not specifically ask doctors if they were responding to our campaign, our figures show that between January and March 2021, 774 additional doctors were granted TER.

17. We did not register any doctors who had a fitness to practise sanction, were under investigation, or had a restriction on their registration at the time they left the register or relinquished their licence to practise; or who had requested us to stop communicating with them.

Deployment of doctors granted TER

[3] As defined in section 19(1)(a) of the Civil Contingencies Act 2004.
[4] This figure was correct as at 16 April 2023 and might include some additional doctors who were granted TER after 3 April 2020.

18. Prior to the pandemic we engaged with partners from the UK health services and the Department of Health (England) about our plans for TER, and how our emergency powers might contribute to a broader pandemic response. This included initial briefings to Department of Health officials on the approximate numbers of doctors who might be registered using TER, and engagement in some planning sessions with the health services, specifically focused on pandemic flu preparedness.

19. From the outset of the TER process, we shared the contact details of TER doctors with the health service in the country of their registered address. This information was updated monthly to ensure that the data was current, including that it reflected changes when doctors opted out of, or back into, TER.

20. Our powers do not require doctors to return to practice and we are not responsible for their deployment. We granted TER automatically on an opt-out basis. Therefore, doctors who were granted TER were able to opt-out of TER at any time, without reason. They were also able to change their mind at any point. This also meant that if they had previously opted out, they could ask us to re-grant their TER. We did this to offer maximum flexibility to individual doctors and the health services.

21. We signposted TER doctors to the relevant UK health services for information on how they could support the pandemic response. This included a survey for doctors in England, Northern Ireland, and Wales, coordinated by NHS England, which asked about their availability and practice. Doctors in Scotland were directed to a survey by NHS Scotland.

Concerns raised about doctors with TER

22. TER doctors are not subject to revalidation[5] and do not have a connection to a Responsible Officer[6] (RO) for revalidation. However, we have been clear to ROs through our outreach advisors and our communications that we expect all doctors

[5] Revalidation is defined on page 9.
[6] A responsible officer is an experienced senior doctor. They are responsible for making sure their doctors review all their work each year at an appraisal and they take action if there are any serious problems.

working in an organisation (including TER doctors) to engage with local clinical governance[7] systems including responding to concerns. In April 2020, we published our policy position on the removal of temporarily registered medical practitioners and a copy of this policy is included at exhibit three [CM/3 – INQ000362207]. In line with this policy, in the event we are notified of a concern about a doctor with TER we would decide whether their TER should be removed.

23. During the relevant period (1 March 2020 to 30 June 2022), we received concerns about 250 doctors who held TER. This compared to the 11,474 concerns we received about doctors with all other types of registration.

24. TER doctors must have adequate and appropriate insurance or indemnity in place when they start to practise. We have regulatory powers to check whether doctors have adequate and appropriate insurance or indemnity. Given the nature of the emergency, many TER doctors would have relied on state-based cover. The medical defence organisations (the Medical Defence Union, Medical Protection Society, and the Medical and Dental Defence Union of Scotland) are responsible for providing medical professional indemnity and might have also provided cover for some TER doctors.

Ending TER

25. Throughout the pandemic we had regular discussions with officials from the Department of Health and Social Care (DHSC) about when TER should end and at what point our powers should be deactivated. We asked for a notice period before the Secretary of State declared the emergency over, so that we could contact doctors who still held TER to let them know their options. For example, if they wanted to continue practising after TER closed, they would need to transition to routine registration. Similarly, it was important to ensure employers knew when TER would conclude so they could maintain service delivery.

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[7] Clinical governance is an overarching term for the processes and systems used by healthcare organisations to monitor and improve the safety and quality of clinical services. It encompasses a range of activities, including (but are not limited to) pre-employment checks for clinicians, risk monitoring, clinical audits, effective information governance, and responding to patient safety incidents.

26. In March 2022, officials informally advised us that we should prepare for TER to close in September 2022. In preparation for this, we surveyed doctors who still held TER, and started removing their registration and/or licence to practise if they told us they were not practising, or they did not intend to return to practise to support the pandemic response.

27. In September 2022, the then Secretary of State for Health and Social Care, the Rt Hon Therese Coffey MP, decided that TER should remain open for two years until at least 2024. At this time, we received a letter, as exhibited at [CM/4 – INQ000377431], from then Minister of State (Department of Health and Social Care), the Rt Hon Robert Jenrick MP, outlining this decision and how TER could be used to support the NHS to maintain its capacity as it continued to deal with the consequences of the pandemic, and in particular the management of the Covid-19 patient backlog. On 11 September 2023, we received a further letter, as exhibited at [CM/5 – INQ000377432] from Minister of State (Department of Health and Social Care), the Rt Hon Will Quince, to confirm that the period of the Covid-19 Emergency in relation to the GMC's Temporary Emergency Registration powers under Part 2 Section 18 of the Act will conclude at the end of March 2024. At the time of writing, we are preparing for the closure of TER and recently contacted registrants and key stakeholders to notify them.

Granting provisional registration

28. We set standards for undergraduate and postgraduate medical education and training in the UK. We promote high standards and make sure that education and training reflect the needs of patients, medical students, doctors in training, and the healthcare systems across the UK.

29. In spring 2020, we worked with the health services in England, Northern Ireland, Scotland and Wales to increase the capacity of the medical workforce, by bringing forward provisional registration of newly graduated medical students.

30. We also fully registered Foundation Year 1 (F1) doctors who applied, and were able to provide a Certificate of Experience from their Foundation School, to

demonstrate they had already met the requirements set out in *Outcomes for provisionally registered doctors* [CM/6 – INQ000326296].[8]

31. All new graduates are given provisional registration. Provisional registration enables them to enter the first stages of their training as a qualified doctor in the two-year Foundation Programme. In spring 2020 we granted provisional registration to final year medical students who met the requirements of their degree, as early as April. We did this so that they could apply for a place in the foundation programme and start work as soon as possible. This one-off initiative in response to the pandemic was called Foundation Interim Year 1 (FiY1). It was not extended beyond 2020 because there was no further request from the Departments of Health. Our aim following the initial response to the pandemic, alongside medical schools and statutory education bodies, was to minimise disruption to education and training as much as possible by supporting medical students and doctors in training to progress normally.
32. We have since commissioned independent research entitled '2020 Medical Graduates: The work and wellbeing of interim Foundation Year 1 (FiY1) doctors' during Covid-19' (2021) to evaluate the impact of FiY1. The researchers identified many benefits, including increasing capacity in the health service and easing the transition from education to practice. FiY1s reported working on various activities including maintaining patient notes, completing discharge documentation, and prescribing medication while working in the areas of end-of-life care, inpatient surgical, and medical wards. You can find this research at exhibit seven [CM/7 – INQ000362208].
33. We set out requirements for the FiY1 posts to make sure that these new doctors were supported in these roles. This included the need for posts to be temporary and to take place within a F1 programme. We stipulated that newly qualified doctors could not be deployed into any service posts.[9] We also stressed that they would need an educational supervisor.

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[8] *Outcomes for provisionally registered doctors* sets out the knowledge, skills and behaviours that foundation year one doctors must be able to show before being eligible to apply for full registration.
[9] This meant that the FiY1 cohort must have been in posts that had an educational element to it so they could demonstrate that they were meeting our outcomes for graduates.

34. Even though we brought forward provisional registration, we made sure that standards were not compromised and that legal requirements were met. We also worked with relevant bodies responsible for delivering education and training, such as the four UK statutory education bodies, medical schools, and with the Medical Schools Council, to make sure they were clear about our requirements for new graduates and to ensure that the current and future training of new graduates was not compromised. To ensure that patient safety continued to be prioritised, we emphasised the need for medical schools to ensure that all graduates continued to achieve the requirements that we set out in *Outcomes for graduates* [CM/8 – INQ000362203]. Additionally, as with all graduating students, they were required to have completed a foundation year and met the outcomes of this before they could have been fully registered.
35. As a result of this initiative, 4,662 FiY1 posts were filled between April and July 2020. We also waived the provisional registration fee for almost 7,000 UK medical school graduates.

Changing the revalidation dates for some doctors

36. Every licensed doctor who practises medicine must revalidate, which requires doctors to demonstrate that they are up-to-date and fit to practise. Revalidation supports doctors to develop their practice, drives improvements in clinical governance and gives their patients confidence that they are up-to-date.
37. We and other organisations across the UK health system wanted to ensure that the processes surrounding appraisal and revalidation did not detract from a doctors' ability to prioritise frontline care. The four UK health departments decided to pause local appraisal and, to support this, we changed the revalidation dates for some of the affected doctors.
38. Revalidation is a continuous process of engagement with clinical governance and appraisal rather than a point in time assessment. We already had the powers we needed, under the Act and our Licence to Practise and Revalidation Regulations 2012, to change the revalidation dates for doctors. We did not require any further statutory amendments. In addition to allowing us to move revalidation dates, our powers also allow us to set revalidation dates for doctors in a range of circumstances. These include bringing forward dates in some cases when a doctor wants to restore their registration with us or has not been engaging with the

revalidation process; or pushing them back in some cases where there have been delays in the completion of formal training.

39. Revalidation continued throughout the pandemic and all our processes remained in place. In April 2020 we moved the revalidation dates of over 60,000 doctors where it was safe and appropriate to do so to give these doctors more time to focus on frontline care during the pandemic. This was for doctors who were due to revalidate before April 2021 and we moved their dates back by 12 months.[10] At other times throughout the pandemic response we moved the revalidation dates for smaller groups of doctors at the specific request of an RO, also putting them under 12 months' notice, to provide ROs with more flexibility to manage local governance systems and make revalidation recommendations.

Deferring revalidation

40. Although appraisal was paused and some revalidation dates were changed, it was still important that steps were taken to maintain standards and ensure patients were protected. To that end, other revalidation processes remained in place during this period. These included processes for ROs to notify us if a doctor was failing to engage in revalidation and processes to enable us to withdraw a doctor's licence to practise if they had repeatedly failed to engage with revalidation over time.
41. Doctors are required to bring evidence of their practice to their appraisal which they can reflect on with their RO. The information they are required to bring includes evidence on continuing professional development, feedback from colleagues, compliments and complaints. The pandemic, and the decision to pause appraisal, meant that when revalidation resumed, some doctors were unable to bring the evidence required to the appraisal process.
42. The most common evidence they were unable to collect was patient and colleague feedback. Consequently, we saw an increase in the number of cases where the RO recommended deferring the revalidation decision until the information could be collected.
43. In this context, it is important to understand that revalidation is continuous process of engagement with local clinical governance leading to ongoing assurance that a

[10] These doctors were also placed under statutory notice for revalidation so that their RO could make a revalidation recommendation when they were ready at any time during those 12 months.

doctor is up-to-date and fit to practise. It is not a point-in-time assessment and doctors are deferred, and may be further deferred, for a range of reasons (for example, long-term sickness or maternity leave). Deferral is a neutral act and does not imply that there are outstanding concerns about a doctor's practise. Without manually reviewing the individual records for the nearly 60,000 doctors who had their revalidation date moved during the pandemic, it is not possible to say whether there were individuals who did not revalidate on their revised date.

44. To support this change, we engaged with individual providers and ROs through our outreach advisors, who work across the UK to improve understanding of our guidance and explain our processes. We wanted to understand the pressures in the system and, in some cases, to agree date changes for some doctors working for providers where there were particular issues in restarting appraisal and other clinical governance systems that support revalidation.
45. Appraisal was restarted by most providers in April 2021 and we began to receive routine numbers of RO recommendations in the following months.

Assessing the knowledge and skills of international medical graduates for UK registration

46. International medical graduates (IMGs) make up a large proportion of doctors on our medical register. We are responsible for assessing the capability of IMGs to practise in the UK before we register them. One of the ways we do this is through the Professional and Linguistic Assessments Board (PLAB) exams.[11]
47. In line with UK government guidelines on social distancing and health and safety in the workplace, we postponed PLAB 2 from March 2020. However, it was important that we continued to process applications from IMGs so those that were suitably qualified could come and practice in the UK. Therefore, as soon as government guidelines allowed, in July 2020, we restarted PLAB 2 in a socially distanced format from our Manchester Clinical Assessment Centre (CAC). We were the first professional regulator to restart these types of assessments.

[11] PLAB 1 is a written exam made up of 180 multiple choice questions. PLAB 2 is an objective structured clinical exam (OSCE). Both parts of the test help us make sure doctors who have qualified abroad have the right knowledge and skills to practise medicine in the UK.

48. This involved commissioning building works to expand the size of rooms and to create more facilities. We also installed video viewing stations in one circuit and social distancing barriers that allowed face-to-face consultations to take place safely. We initially ran one exam circuit a day but expanded this to two as we became more confident in our health and safety procedures.

49. In June 2021, we opened a new socially distanced temporary CAC to increase our testing capacity for overseas doctors who want to practise in the UK, making a direct contribution to increasing the capacity of the healthcare system to respond to the pandemic. We designed and built a unique socially distanced exam circuit using 25,000 square feet of office space. Once opened, this allowed us to examine candidates at the same rate as we could before the pandemic. By November 2021, we had exceeded our pre-pandemic testing capacity.

50. When we closed our offices in March 2020, we quickly became aware that a number of doctors from overseas who had booked a PLAB 2 test were in the UK. These doctors were initially unable to return to their home countries. We worked with a range of organisations who support IMGs, including the British Association of Physicians of Indian Origin, to identify which doctors this applied to. We gave them priority access to PLAB 2 and waived the test fee for this cohort when we resumed testing in July 2020.

The impact on medical education and training

51. The pandemic also had an impact on postgraduate trainees, many of whom struggled to continue their training. From March 2020, we jointly issued successive statements with the four UK statutory education bodies and the Academy of Medical Royal Colleges on changes we were making to minimise the disruption caused by the pandemic for trainees in foundation and specialty training programmes. These statements can be found at exhibit nine [CM/9 – INQ000362209].

52. The changes were based on five principles:
    a. maintaining patient safety as paramount;
    b. maintaining standards;
    c. focussing on a holistic assessment of a doctor's competency, not the quantity of assessments of clinical activity completed;

d. whether outcomes are achieved and not the time spent working in a particular area; and
e. the need to maintain proportionality and support diversity.

53. Some of these changes were extended until September 2023 in response to the continued disruption caused by the pandemic.

54. The changes were:
    a. exemptions[12] allowing trainees to progress without meeting all of the requirements of the curriculum. In most cases, this was only for one training year without having completed the exams; not beyond a critical progress point; and with the standard for the certificate of completion of training and entry to the specialist and GP register remaining the same[13];
    b. changes to exam formats and processes to allow them to continue when possible;
    c. changes to the format and composition of the annual review of competence progression (ARCP)[14] panels and processes to allow for trainee progression;
    d. the introduction of new ARCP outcomes to recognise that the trainee was achieving progress and developing competences/capabilities at the expected rate but that the acquisition of some capabilities had been delayed by the impact of Covid-19.

55. A range of innovative solutions were proposed by colleges and faculties to enable exams and clinical assessments to run during the pandemic to support doctors to continue to progress through training where it was safe to do so. These included:

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[12] Exemptions or 'derogations' were revised requirements for meeting our *Outcomes for graduates*. Training programmes were able to propose curricula exemptions to allow the progression of postgraduate trainees so they could focus on achieving training outcomes. These exemptions were approved by the GMC.

[13] This was updated in 2021 to account for the ongoing impact of the pandemic on training to allow more flexibility to progress more than 12 months without an exam, and that trainees were expected to pass the exams before completion of training.

[14] Deaneries and local offices review the progress of all doctors in training at least annually and award them with an ARCP outcome (depending on when they started their training). These reports compare the rates of unsatisfactory outcomes across different specialties. They are intended to help training organisations to identify where variation exists and to investigate the underlying cause.

a. written exams previously delivered in exam halls that were converted to computer test centres to expand the number of centres or size of cohorts that can sit the test at any one time;
b. written, oral and OSCE style assessments that were moved online using remote invigilation or video-conferencing technology;
c. mixed delivery models combining both physical and remote online delivery to meet the different needs of candidates.

56. Towards the end of 2022, we commissioned independent research on the changes. Some of the preliminary findings indicate:[15]
    a. changes made to curricula during the Covid-19 pandemic were perceived as pragmatic and compassionate, focusing on essential competencies and facilitating progression for trainees amidst significant disruption;
    b. the significant changes and disruptions to trainee exams (cancellations, online exams etc.) caused uncertainty and stress for trainees, with significant concern about potential bottlenecks from exam cancellations and extensions to training;
    c. trainees voiced increased pressure to pass exams due to potentially reduced timeframes in which to pass and felt underprepared due to the lack of access to exam-specific teaching and patients.
57. In the 2020 National Training Survey (NTS), most trainees reported that their training was disrupted and that this reduced their opportunities to gain competencies, whether their workload became heavier, lighter or did not change. A copy of the NTS summary report is available at exhibit 10 [CM/10 – INQ000362210].
58. Three quarters of trainees also told us that they faced disruption to their formal training. However, most reported that other aspects of on-the-job learning, such as clinical supervision, remained of high quality.
59. Many trainees were redeployed to different specialties or sites because of the pandemic. To facilitate this, we approved approximately 550 additional training

[15] At the time of writing, the final report is likely to be published in the beginning of 2024 and it should be noted these preliminary findings may change once the final report is published.

locations so that doctors working at them could count this experience towards their training progression.

Adapting our fitness to practise processes

60. When a serious concern is raised about a doctor's performance, behaviour, or health, we take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

61. During the pandemic, we introduced greater flexibility in our processes to enable a focus on two key priorities. The first was to continue to protect patients by taking action to address any serious risks posed by doctors, but in doing so minimising our impact on employers, ROs, and the healthcare workforce. The second was to adapt our existing guidance for our fitness to practise decision makers to support them to make proportionate and effective decisions about concerns raised with us linked to care provided under highly unusual circumstances.

62. To achieve our first priority, we shifted from in-person to virtual meetings for several aspects of our fitness to practise processes. These included doctors undergoing health assessments, taking witness statements, and meetings with patients who raised concerns about a doctor.

63. In all cases, we continued to prioritise our risk assessment of concerns so that we could determine whether there was a patient safety risk. We decided to prioritise any cases that may have required an interim order,[16] which meant that it had the potential for immediate patient safety concerns. We also prioritised cases where the doctor under investigation requested that we continue; and cases where the investigation did not require evidence from providers in the NHS that were under significant pressure.

Updating our fitness to practise decision making guidance to account for the pandemic

[16] Interim orders tribunals decide if a doctor's practice should be restricted while an investigation takes place. At any point during our investigations, the GMC can refer a doctor to an interim orders tribunal at the MPTS.

64. In September 2020, we published new guidance to assist our decision makers to make decisions about a doctor's fitness to practise in the context of the pandemic. This can be found at exhibit 11 [CM/11 – INQ000377427]. The guidance intends to ensure that decision makers understand and consider the specific context and individual circumstances surrounding a complaint consistently and fairly, together with the wider system or environmental pressures that are beyond a doctor's control.

65. We developed this guidance by gathering as much evidence as possible through our existing channels. This included:

    a) ensuring our guidance was aligned with the advice on professional standards that we provided to doctors in our online Covid-19 ethical hub (explained further below) from the start of the pandemic. We used this information to inform examples of different types of circumstances set out in the guidance which indicate that a concern may or may not be relevant to a doctor's fitness to practise;

    b) data from our investigation teams about the types of concerns being raised with us;

    c) input from our outreach advisors regarding the difficulties doctors were facing throughout the pandemic and the impact on local processes;

    d) reports from our horizon scanning function on the range of challenges that arose during the pandemic, such as workforce pressures, changes to healthcare delivery and the impact of Covid-19 on equalities;

    e) extensive engagement with key stakeholder groups, including medical defence organisations, the British Medical Association (BMA), and patient groups to gather their feedback on the guidance. We also spoke with other professional regulators to identify any similarities or differences in approach.

66. The guidance was based on a set of key principles that could be applied to a wide range of circumstances. Based on our best intelligence, it contains examples of different types of circumstances that our decision makers might come across when dealing with complaints about care provided during the pandemic.

67. However, as with all our guidance, these examples are provided to help decision makers understand and apply a set of principles, and not to constrain their decision making. They are non-exhaustive examples, and each case must be assessed on the individual circumstances of that case, including what conditions the doctor was working in, to determine if their actions were a reasonable response to the circumstances in which they were required to work.

68. Paragraph 10 of the guidance says that 'decision makers should take into account the specific issues relating to the circumstances which have arisen as a result of the Covid-19 pandemic that include, but are not limited to, [...] changing and sometimes conflicting guidance and protocols, often produced and communicated quickly.' We had initially decided to track and maintain a repository of Covid-19 guidance that was provided to healthcare professionals throughout the pandemic. However, through doing this, we quickly realised that the scale and pace of guidance being produced and the changes being made meant that this was not a viable approach. We therefore wanted to ensure that our guidance to decision makers made them aware that changing guidance and protocols may form part of the context that needs to be taken into account when reviewing a concern. As the events of the pandemic were unprecedented for our decision makers, the guidance sets out the types of factors that they may need to take into account when considering the extraordinary context in which doctors were working.

69. When assessing the context in individual cases, they would look to the evidence provided by the registrant, their employer or other third party to determine to what extent a particular contextual factor was material to the specific allegations that had been made. Where the availability of evidence was impacted by the circumstances of the pandemic, decision makers would weigh submissions about contextual factors against our general understanding of the impact of the pandemic on the context in which doctors were working based on intelligence obtained through our existing channels.

70. Similarly in paragraph 10, the guidance says that decision makers should consider 'the effectiveness of existing clinical governance processes creating unexpected challenges for leaders and managers.' Due to the additional pressure put on the NHS and healthcare services during the pandemic, it would not have been proportionate for us to directly engage with healthcare professionals in the

development of our guidance. However, we did gather intelligence through our existing channels (as outlined above) and this informed us that the usual processes for clinical governance, for example escalating or reporting issues, were not working in some environments as effectively as they were pre-pandemic. Our intention by including this in the guidance was to make sure that decision makers were aware of the range of factors that were present and may have had an impact on the context in which healthcare professionals were working in at the time, to help them to assess evidence of contextual factors specific to the pandemic in an informed and consistent way.

71. When we became aware of new information about the pandemic, we assessed whether to update the guidance. As the guidance is based on principles, supported by examples, it was not necessary to do this often. However, we did update the guidance in January 2022, so that it was more specific about the impact of the sustained nature of the pandemic on issues such as fatigue, the availability of resources, and workforce shortages.

Concerns about the spread of misinformation

72. During the relevant period, we received over 400 concerns about doctors alleged to have spread misinformation about the Covid-19 pandemic, including through the use of social media. Around 200 of these complaints were made against eight doctors. The vast majority of these concerns did not meet our thresholds for an investigation.

73. When deciding whether a concern meets our threshold for investigation, decision makers assess the overall risk to public protection posed by a doctor on a case-by-case basis. Protection of the public includes:

    a. protecting and promoting the health, safety and wellbeing of the public;
    b. promoting and maintaining public confidence in the medical profession;
    c. promoting and maintaining proper professional standards and conduct for the members of the profession.

74. As part of assessing fitness to practise concerns, and to reach a decision on whether a doctor poses any risk to public protection, we consider:

    a. the seriousness of the concern. This includes looking at how far a doctor has departed from the professional standards set out in *Good medical*

practice. Or, if relevant, it includes considering if a health condition is having an impact on their ability to practise safely;

b. any relevant context that we are aware of. By 'context' we mean the specific setting or circumstances that surround a concern;

c. how the doctor has responded to the concern.

75. Of the cases that we formally investigated, five doctors were referred to a Medical Practitioner Tribunal. At the time of writing, three have had sanctions imposed and two doctors are awaiting an outcome.

76. We carefully consider all concerns raised with us, and thoroughly review all relevant information before making decisions about whether they meet the statutory threshold for investigation.

77. We expect doctors providing advice or commentary online to act in accordance with the core professional standards in *Good medical practice* and our more detailed guidance on *Doctors' use of social media* [CM/12 – INQ000326299]. We are considering learning points from complaints made about doctors' conduct on social media as part of our current work to update our social media guidance.

Continuing to operate medical practitioner tribunals

78. During the pandemic, the Medical Practitioners Tribunal Service[17] (MPTS) adapted how it ran hearings by holding these virtually rather than in-person. They did this to comply with social distancing guidelines and to ensure they could continue the service, conduct more hearings, and run them more efficiently. This flexibility eased the burden on both doctors and patients, such as those with accessibility requirements or caring responsibilities. We found that facilitating virtual evidence more frequently can provide a better experience for some individuals without having an impact on the hearing itself. The MPTS has since retained this approach for its daily operations.

79. The MPTS also introduced an increase in the number of medical practitioner tribunals and interim order tribunals cases that could be reviewed on paper without

[17] The MPTS is an independent tribunal service which makes independent decisions about whether doctors are fit to practise medicine. It is separate from the investigatory role of the GMC. It is overseen by a committee whose role is defined in legislation.

the need for the doctor or other parties to attend. The MPTS has since maintained this approach, leading to continuing benefits post-pandemic.

Section two: Supporting doctors facing challenging situations by advising on the application of our professional standards in the context of the pandemic

Providing reassurance and responding to questions about ethical practice

80. Our standards define what makes a good doctor by setting out the professional values, knowledge, skills, and behaviours required of all doctors working in the UK. We work closely with doctors and patients and groups representing their interests, as well as other stakeholders, to develop and agree on the professional standards.
81. Covid-19 presented unique challenges for doctors and other healthcare staff. A range of ethical issues were emerging, and questions were being raised about how best to meet the needs of patients. The concerns that were raised to us by doctors and members of the public are further outlined in this section.
82. We issued a joint statement with other professional regulators on 3 March 2020, recognising that professionals might need to depart from established procedures in the circumstances presented by Covid-19. A copy of this statement is attached at exhibit 13 [CM/13 – INQ000326301]. We did not have specific established procedures in mind. We wanted to reassure our registrants that if the impact of the pandemic meant that they needed to depart from usual practice, for example by adapting existing clinical guidelines or organisational protocols to meet the needs of their patients, we would take this into account if we received a complaint about their practice.
83. As the realities of Covid-19 started to emerge, doctors and other healthcare professionals were expressing concerns about the complex decisions and challenges they were confronting, and the sense that there was not enough published guidance or other readily available support to meet their needs, and to be provided with reassurance that they would not be unfairly criticised for their actions and decisions. We issued a further statement on 11 March 2020 with the CMOs of the UK. A copy of this statement is attached at exhibit 14 [CM/14 – INQ000326302]. The statement acknowledged that the pandemic would require doctors to be flexible and might involve working in unfamiliar circumstances or

clinical areas outside of their usual practice. We emphasised the role that GP practices, hospitals, trusts, and health boards had in supporting doctors, especially as they may be caring for patients in highly challenging situations. The statement also reassured that we would take the context into account if any concerns about a doctor's fitness to practise were raised with us.

84. We worked to provide advice at pace in response to emerging issues. We were mindful that our advice on ethical practice needed to be coordinated with that provided by other organisations, such as the medical royal colleges, the BMA, governments, other regulators, and health bodies. To do this, we built up our insight into the practical realities facing doctors and patients across the health and care system, pandemic-specific legal requirements, and national guidelines. We also maintained strong working relationships with key clinical staff in local and national healthcare provider organisations.

Provision of ethical advice

85. In March 2020 we decided to fast track the provision of advice on ethical standards of practice in the context of the pandemic. This included setting a shorter (three day) turnaround time for replying to Covid-related enquiries. We allocated a pool of staff to this work to increase our capacity. We also created a process to track the number of enquiries and types of issues raised, to increase our ability to be responsive to issues as they emerged.

86. The queries we received in relation to standards of care for patients affected by Covid-19 were mainly set around:

    a. a lack of personal protective equipment (PPE) for staff and how to manage the implications for their own safety and patient safety;
    b. concerns about how to respond to patients refusing to follow infection control measures, for example, using face masks or self-isolating after a positive Covid-19 test;
    c. concerns raised by doctors who were expected to take on roles outside of their usual area of practice; mainly about their access to training, supervision, and the potential risks to patients;
    d. concerns about the rapid increase in remote consultations in response to Covid-19. For example, how to ensure patient privacy and dignity when carrying out intimate examinations by video call, and how to address child

protection and adult safeguarding responsibilities remotely, including questions about recording and transmitting intimate images;

e. wider concerns about decisions that impact patients' access to treatment and care, including different approaches to treatment escalation, and the prioritisation and management of non-Covid-19 healthcare demand;

f. uncertainty around changes to familiar processes, for example, managing aspects of end-of-life care and death certification.

87. We also received a small number of direct enquiries about a range of issues concerning the care of dying patients and care after death. These included questions about families having access to dying or deceased relatives, legal and procedural changes relating to which doctors could sign death certificates and cremation forms, and how this might impact doctors and patients of particular faiths.

88. We expect doctors to take steps to manage their own health condition(s), including by seeking advice from experienced colleagues. We outline these steps in paragraphs 28 and 29 of *Good medical practice* (2013). A copy of *Good medical practice* is included at exhibit 15 [CM/15 – INQ000362200]. Our online ethical hub (further explained below) included advisory content on doctors getting vaccinated, employers carrying out risk assessments of clinically vulnerable doctors, and doctors taking steps to protect themselves from the risks posed by Covid-19. As our role is to provide advice on queries related to ethical standards of practice, we do not provide clinical advice to doctors and we do not have any role in advising on infection control measures. Therefore, we did not issue any practice guidance for doctors who were clinically vulnerable. Similarly, we are not aware of any instances of doctors raising concerns with us about providing medicines and treatments to patients designated as clinically vulnerable, clinically extremely vulnerable or on the Highest Risk List.

89. In October 2021, we responded to the DHSC's consultation on making vaccination against Covid-19 and influenza a condition of deployment in the health and wider social care sector. Our response, as outlined at exhibit 16 [CM/16 – INQ000362201] said that while we do not set an absolute duty to be vaccinated against any particular disease, we recognised the potential risk of inadvertently spreading coronavirus to vulnerable patients, and that this weighed in favour of

doctors being vaccinated unless there were good reasons not to be. The proposals were that vaccination would be a condition of deployment and compliance would therefore be a matter for employers to address.

90. We also outlined some potential challenges that we could see with the consultation proposal. We suggested that they would benefit from further consideration and offered to work with DHSC to explore how to minimise them. These challenges included possible implications in relation to:
    a. international medical graduates and other healthcare professions coming to the UK from abroad who either had not received a vaccine or received a vaccine which had not been approved by the Medicines and Healthcare Regulatory Authority;
    b. unintended workforce impacts. For example, if a requirement to be vaccinated were to lead some employees to change roles or leave the sector;
    c. some variation in vaccine uptake between groups with protected characteristics and equality and diversity impacts to consider;
    d. discomfort amongst vaccinators if they felt that an individual's choice to receive a vaccination was unduly influenced by a deployment requirement;
    e. a lack of clarity about whether the Government's proposal would have been a temporary measure to deal with an emergency situation, or a longer-term change to deployment requirements.
91. Our understanding is that following the consultation, the Government introduced regulations to make vaccination a condition of deployment but subsequently revoked these. We were therefore not asked to do any further work with the DHSC on this issue.
92. In February 2022, along with other healthcare regulators, we were asked by the Rt Hon Sajid Javid MP, then Secretary of State for Health and Social Care, to review what our guidance stated about the vaccination of healthcare professionals against Covid-19. In response to this, we issued a joint statement [CM/17 – INQ000356267] with the Academy of Medical Royal Colleges, in which we set out the importance of vaccination and reiterated the existing principles in our guidance. We shared this with CMOs across the UK and published it on our website.

93. We do not keep records for or have details of the number of registrants who died of, or became infected with, Covid-19 during the relevant period.

Creation of our Covid-19 hub

94. Throughout the pandemic period, as we responded to individual queries about applying the professional standards in our guidance to the range of ethical and operational challenges created by the pandemic, we considered how we could use our website and other communication channels to share our advice more widely. In April 2020, we created the Covid-19 hub on our website as a space where our advice could be easily accessible for everyone. We were aware of emerging concerns that the amount of guidance being published by different bodies would make it difficult for busy professionals to find what they needed quickly and be confident that the same expectations were being set by different organisations. We decided to use the hub to focus on providing practical advice, linking to helpful resources published by other national bodies such as the Departments of Health, NHS organisations, and medical royal colleges. To help guide patients and the public, we also had information which signposted to the latest advice from the UK government, and other relevant resources.
95. Content on the hub is attached at exhibit 18 [CM/18 – INQ000377428] and included:

    a. reassurance to doctors that it was reasonable to consider their own vulnerabilities and exposure to risks when discussing deployment and redeployment to frontline care with their employer;

    b. a reminder of our expectation that doctors take steps to protect patients from risks posed by their own health, and that they should be immunised against common serious communicable diseases, unless contraindicated. We also highlighted the importance of doctors seeking support for their own wellbeing and any psychological or moral distress they might be experiencing;

    c. highlighting employers' responsibilities for supporting healthcare staff. For example, by carrying out risk assessments and providing appropriate protective equipment;

d. reminders about good practice in relation to advance care planning, cardiopulmonary resuscitation (CPR) decisions, and managing palliative and end-of-life care;

e. links to resources published by the UK government and national bodies, including decision-support tools, to provide a one-stop source of advice wherever possible.

96. We published updated advisory content on the Covid-19 hub on remote consultations in response to the rapid adoption or expansion of the use of these technologies as outlined in exhibit 18 [CM/18 – INQ000377428]. The content helped guide doctors through factors to consider when deciding whether a remote or a face-to-face consultation was appropriate. It included links to our guidance on *good practice in prescribing and managing medicines and devices* [CM/19 – INQ000356268], which was updated in the context of the pandemic to reflect an increase in the use of remote consultations. All of our ethical guidance and advice is necessarily high-level so that it is applicable to doctors working in all settings and enables them to use their professional judgement in deciding what to do. We also signposted to other resources such as shared high-level principles for remote prescribing for all health care professionals co-authored by 13 health bodies (published in November 2019).

97. The Covid-19 hub has now been archived from our website. However, its positive reception from doctors has led to an increase in the number of doctors using other resources on our main ethical hub. Many of the overarching principles in the Covid-19 hub have been integrated under our ethical hub theme *Working under pressure*. This content has received positive feedback and our data suggests that it continues to be helpful to doctors.

98. During the pandemic, we continued to publish content on our ethical hub. One of the topics we added aims to help doctors tackle racism in healthcare workplaces. We started developing advice on this issue following concerns raised in a number of enquiries received by our Standards team about how doctors should deal with racially motivated behaviours towards ethnic minority staff, and in light of reports on the findings of NHS staff surveys around this issue. In addition, our public commitment to treating racism, discrimination, and inequality in medicine as an urgent priority for action provided further support for our decision to publish advice

(further context can be found in the section on 'learning from the pandemic: effect on equalities'). We also provided registration and demographic data of doctors to the UK Research Study into Ethnicity and Covid-19 outcomes in healthcare workers (UK REACH) to help with their research into the disproportionate impact of the pandemic on ethnic minority doctors.

DNACPR and advance care planning

99. We learnt via media reports in March and early April 2020 that in some places, contrary to standards of good practice, do not attempt cardiopulmonary resuscitation (DNACPR) policies were being put in place to cover some groups of patients being discharged from a local hospital, and residents in some care homes. Some individual decisions were being put in place without any discussion with the person who would be affected or their family. This was not in line with good practice as set out in our guidance on *Decision making and consen*t [CM/20 – INQ000346167] and *Treatment and care towards the end of life* [CM/21 – INQ000346168].
100. In response to the level of ongoing concern, we published a joint statement with the Nursing and Midwifery Council (NMC) on 15 April 2020. It reminded health professionals about the expected standards of practice for advance care planning, including responsibilities for consulting patients, and their family members where appropriate, about future CPR and DNACPR decisions. A copy of this statement is included at exhibit 22 [CM/22 – INQ000326295]. We also used the opportunity to signpost doctors to the Resuscitation Council UK's (RCUK) work to update and promote their Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) guidelines. This approach helps to create and record a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.[18]
101. We have also set expectations related to basic life support skills for newly qualified doctors in our *Outcomes for graduates* [CM/8 – INQ000362203]. These outcomes describe what newly qualified doctors, from all medical schools who award UK primary medical qualifications, must know and be able to do when they graduate.

[18] Further information can be found on RCUK's website.

102. Early in the pandemic we provided support to the Department of Health (Northern Ireland) to develop their national CPR policy [CM/23 – INQ000377426]. We were able to draw on our own guidance and previous related work with relevant stakeholders in England, Scotland, and Wales, to provide expert advice based on our experience of implementing similar guidance for doctors. We were invited to attend meetings to share our experience, and we were consulted on a draft of the final policy.

103. In March 2020, the NHS England and NHS Improvement Ambitions Partnership led work to develop advice on good practice related to end-of-life care. This included topics on pain management and support for family members in the context of the pandemic. We used our Covid-19 hub webpages on advance care planning and end-of-life care to promote the recommendations.

104. In October 2020, the DHSC commissioned the Care Quality Commission (CQC) to undertake a rapid review of approaches to DNACPR in England during the pandemic, with the aim to have a shared approach to good practice. We joined the CQC's external advisory group and subsequently joined the DHSC's CPR national steering group, which is working to develop and implement a national policy for England.

105. Throughout the pandemic, we responded to all issues that were flagged to us, including those identified through our outreach and insights teams, and our engagement with the DHSC's Moral and Ethical Advisory Group (MEAG). It is therefore difficult to identify whether there are any specific ethical issues, beyond those on which our advice was sought, where it would have been helpful for us or other regulators to provide advice during the relevant period.

Section three: Collaborating with other regulators and system partners across the UK to ensure clear, consistent advice, guidance, and messaging

106. Given the variety of advice being produced by a range of different organisations, and the demand for this, it was important to pool expertise between key organisations wherever possible, so that we could develop a consistent approach and shared view on ethical issues. This supported our need to respond to queries at pace with robust reliable advice.

107. For example, our Standards team made a number of arrangements for mutual support and participated in more formal initiatives with other groups.[19] A good example is our collaboration with the Royal College of Physicians in 2021 who were developing and piloting support tools for managing discussions in critical care between clinicians, patients, and their families about appropriate levels of treatment.

Working across the UK

108. From the outset of the pandemic, we collaborated and communicated with partners, including government departments, in England, Northern Ireland, Scotland and Wales. This supported our work to develop nationally relevant, well-informed advice on applying our professional standards; to explain and explore the impact of changes to the operation of our registration, fitness to practise and education quality assurance processes; and to promote any new GMC resources for doctors, patients, and the public.

109. Throughout the pandemic, we continued to meet regularly with professional regulator counterparts across the UK at senior level to discuss the approach to TER and the number of professionals re-joining the register and being deployed in the NHS. The impact of the pandemic on education and training was also a key theme as we sought to minimise disruption for students and ensure they continued to gain the practical experience necessary for graduation. We also shared experiences of best practice in handling fitness to practise cases during the pandemic, including the move to virtual hearings. We sought to learn from overseas medical regulators, including the experience of those who introduced virtual clinical assessments for the purposes of registration.

110. In autumn 2020, we continued to host our bi-annual UK Advisory Forums in Northern Ireland, Scotland and Wales. These meetings help us to understand how people experience our regulation on the ground, and how to continue to improve it. We used the platform to share our response to Covid-19 in each country and

[19] These included: the UK Clinical Ethics Network; DHSC's Moral and Ethical Advisory Group; Resuscitation Council UK; the Royal College of Physicians, the UK Pandemic Ethics Accelerator project, and the Nuffield Council on Bioethics.

seek advice on our approach from key stakeholders. At the forums, we discussed how we met the challenges of the pandemic, lessons learned, and how we could move forward collectively with our recovery plans. The forums also provided us with insight on how the health systems in each country were experiencing the pandemic and the extent to which they were affected.

111. In September 2020, we responded to the Department of Health (Northern Ireland)'s Surge Planning Strategic Framework by providing information on the number of doctors granted TER and the various measures introduced, including, provisional registration, and the application of our standards in relation to changes in revalidation and on the use of remote consultations, that we were using to support doctors in Northern Ireland. During our UK Advisory Forums in Northern Ireland in 2020 and 2021, we discussed with key stakeholders the deployment of doctors with TER in Northern Ireland, the workforce pressures faced by doctors, including the pressures faced by Medical Directors and how this may impact on their Responsible Officer duties in relation to revalidation. The forum considered the impact on patients in Northern Ireland, and specifically the Patient and Client Council (PCC)'s research into patients' experiences of the pandemic leading to an agreement to seek the views of patients about changes made as a result of the pandemic and future decisions about rebuilding services. Forum members also highlighted some of the positive outcomes from changes during Covid-19, which included examples of more regular communication between bodies, data sharing and innovation. We also signposted doctors with TER to Northern Ireland's Health and Social Care Workforce portal to aid with deployment.

112. In Wales, we discussed our flexible approach to revalidation dates, the importance of protecting doctors' wellbeing and psychological safety, TER, and PLAB 2 testing arrangements with the Welsh Government. These conversations allowed for frequent communication about our initiatives and provided us with insight into the impact of outbreaks and infection control measures, as well as workforce pressures. We also liaised regularly with Health Education and Improvement Wales (HEIW) to discuss the impact of Covid-19 on training placements and trainees' experiences. We engaged with the body's Revalidation Support Unit about their plans for appraisal which helped inform our policy on changing revalidation dates for affected doctors. We also regularly attended joint meetings

with representatives from Health Inspectorate Wales (HIW) and other professional regulators such as the NMC, to provide updates on the ongoing pandemic response, including the use of TER, holding virtual fitness to practise hearings, changing revalidation dates, and our Covid-19 hub.

113. In Scotland, over the summer of 2020 we contacted NHS Boards to ask how we could best meet their needs during this challenging time. We continued to offer support – such as how to optimise the use of doctors with TER – and had conversations about the wellbeing of doctors in their organisations. We frequently met with other professional regulators[20] to discuss topics such as PPE supply issues, TER, workforce wellbeing and vaccination roll-out; and to identify any collective concerns. For example, we considered registrants' concerns about the availability of PPE and the sometimes conflicting guidelines on its use. We shared our approaches to providing early registration for final year students and the ways they were being deployed, along with difficulties ascertaining how many registrants with TER or early registration were being deployed. We also considered emerging trends and consistency of approach in referrals to regulators about concerns such as registrants' use of social media and failure to follow government guidance on PPE and social distancing. We also contributed to the NHS Education for Scotland medical student workforce steering group by having weekly meetings to answer any queries and provide updates to support the effective deployment of the FiY1 cohort. We collaborated with BMA Scotland and the Scottish Academy of Medical Royal Colleges through the Medical Workforce Wellbeing Stakeholder Group. Through this, we shared our views with the Scottish Government to support their work to improve medical wellbeing across NHS Scotland. Areas of focus included: the establishment and implementation of the Workforce Specialist Service; promoting the need for rest and relaxation places for staff; sharing our concerns about fatigue in the workplace; and the prioritisation of wellbeing within NHS recovery plans.

[20] Nursing and Midwifery Council (NMC), General Dental Council (GDC) and General Pharmaceutical Council (GPhC)

Section four: Our learning from the pandemic and resulting recommendations for arrangements in future healthcare emergencies

114. As an organisation, we have reflected on our experience of the pandemic, the changes we have retained as part of our day-to-day work and how we could build on our response to support system wide efforts in the event of future healthcare emergencies.

Effect on equalities

115. We know that the pandemic affected everyone, but there were some groups with shared protected characteristics[21] that were specifically and more significantly impacted. As the BMA's research[22] and other research highlighted, ethnic minority doctors and disabled doctors were among those whose physical health was more negatively impacted by the pandemic than their peers. Additionally, the pandemic impacted the health and wellbeing, and financial and career progression of some medical professionals. *The state of medical education and practice in the UK* reports from 2020 and 2021 provide additional evidence on how the pandemic affected doctors [CM/24 – INQ000326297 and CM/25 – INQ000326298]. For example, our data shows that doctors from a Black and Minority Ethnic (BME) background were impacted more negatively because of the pandemic overall compared to white doctors. BME doctors also reported a worse experience in relation to the sharing of knowledge and experience across the medical profession and the speed of implementing change. Further research is needed to understand why doctors from a BME background had a disproportionate negative impact on their day-to-day work during the pandemic.[23]

116. In relation to patients, the pandemic has shone a light on some of the health and wider inequalities that persist in our society. Covid-19 has had a disproportionate

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[21] There are nine 'protected characteristics' under the Equality Act 2010. They are sex, age, disability, race, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment, and marriage and civil partnership. Section 75 of the Northern Ireland Act 1998 does not refer to 'protected characteristics' but instead includes a statutory obligation on public authorities to promote equality of opportunity between: people of different religious belief, political opinion, racial group, age, marital status or sexual orientation.
[22] British Medical Association, BMA Covid Review 2: The impact of Covid-19 on the medical profession, (2022).
[23] GMC, *The state of medical education and practice*, page 12, (2020).

impact on many who already face disadvantage and discrimination, for example, those living in areas of high deprivation, on ethnic minority communities, on older people, and those with disabilities such as a learning disability.

117. During the pandemic we worked closely with our key stakeholders including members of our Strategic Equality, Diversity, and Inclusion Advisory Forum, and the Black and Minority Ethnic Doctors Forum to inform the support we put in place for those who share protected characteristics. [24] This included supporting overseas doctors taking PLAB 2 who were stranded in the UK, using digital instead of face-to-face delivery models for our services, and putting specific support in place for our own staff during the pandemic.

118. In May 2020, we submitted evidence to the House of Commons Women and Equalities Select Committee's inquiry into the impact of Covid-19 on people with protected characteristics. A copy of our evidence is attached at exhibit 26 [CM/26 – INQ000362204]. The evidence referred to the key findings of independent research we commissioned prior to the pandemic that found some groups of doctors face significant additional pressures in the workplace. We also highlighted the equality analysis that we conducted which considered the impact on doctors who were granted TER and the impact on refugee doctors and IMG doctors waiting to take their PLAB exams. The analysis of doctors granted TER found that they were more likely to be male and in older age categories. We considered whether granting TER could have an adverse impact on the specific groups of doctors and took steps to minimise the potential impact on them, which included ensuring that all doctors had the option to opt out if they did not wish to be involved and minimising the administrative and/or financial burden by automatically registering them and waiving the registration fee.

119. In addition, we noted the impact of the pandemic on doctors in training. However, there continues to be limited evidence about the pandemic's effect on differential

[24] We hold these meetings so that we can listen and respond to the experiences of doctors with a diverse range of backgrounds and interests. The forums help us meet our equality, diversity and inclusion objectives by raising relevant issues to develop appropriate responses, commenting and advising on the development of our policies and strategies, and giving us an opportunity to seek views on and raise broader awareness of our priorities and progress.

attainment. We recognise that the impact of the pandemic may have exacerbated existing differentials in experience and outcomes for ethnic minority and IMG doctors and we continue to monitor this. More broadly we are continuing to improve the transparency of data on equality, diversity, and inclusion in a variety of ways and seeking to improve our evidence base and insight. Some examples include:

a. developing our interactive data tool, Data Explorer, to expand its capability to analyse data on our medical register by protected characteristics;

b. surveying doctors, including different groups such as Specialty and Associate Speciality (SAS) and Locally Employed (LE) doctors, to find out more about their experiences in the workplace and to highlight disproportionality in representation for each group;

c. continuing to share evidence of differentials in our data, surveys, and research across a range of publications and including more data on protected characteristics in our *State of medical education and practice* reports;

d. including new questions in the national training survey that cover topics such as unfair treatment, stereotyping, and confidence in reporting discriminatory or unprofessional behaviours;

e. publishing enhanced equality, diversity, and inclusion data on the extent of persistent inequalities in the progression of doctors' medical careers. For example, the specialty exam pass rate of UK-trained black doctors and UK-trained white doctors differs by 18%.[25]

120. The pandemic has been a catalyst to help us tackle discrimination and inequality in medicine, which is an urgent priority for everyone supporting the health services. We believe that it is the right and fair thing to do and is vital to helping retain doctors working in the UK and to support high quality patient care. Using research and data, we have identified a number of areas of inequality which we and other

[25] General Medical Council, *Tackling disadvantage in medical education: Analysis of postgraduate outcomes by ethnicity and the interplay with other personal characteristics* (2023).

organisations are working together to address. We have set aspirations to help us all keep focused on creating long-lasting changes.

121. We want to eliminate two areas of inequality affecting doctors. These are:

    a. by 2026, the disproportionate pattern of fitness to practise complaints we receive from employers, in relation to a doctor's ethnicity and place of qualification;

    b. by 2031, discrimination, disadvantage, and unfairness in undergraduate and postgraduate medical education and training.

122. We also need to improve diversity and inclusivity in our organisation. We have set targets for ourselves as an employer to: increase progression for ethnic minority colleagues; improve the representation of ethnic minority colleagues at all levels; and address gender and ethnicity pay gaps.

123. We have established significant programmes of work both internally and with organisations across the UK to create long-term improvements on the aspirations we have set. An example of this is our fairer training cultures programme of work which has evolved from data and research into the causes of differential attainment in medical education and training prior to the pandemic. This programme initially focussed on evidencing differential attainment through exam, ARCP, recruitment and national training survey data, in addition to commissioned research. It has now progressed to an action focussed phase where we are encouraging and monitoring the equality, diversity, and inclusion work of those responsible for medical education and training through our quality assurance processes. We are collaborating with others to develop and evaluate interventions and raise awareness of differential attainment. We are also developing further resources which will support trainees and trainers in the future.

124. We continue to report annually on progress against these measures to ensure that we shine a light on inequalities where they continue to exist. We have exhibited the reports from 2022 and 2023 to this statement [CM/27 – INQ000377429 and CM/28 – INQ000377430]. The reports are updates on progress that we and others have made to help meet the ED&I targets we introduced in 2021. We recognise that addressing these inequalities is beyond our sole control. In setting our targets,

we have aspired to create sustained focus across the health system on these critical areas. If we are successful in achieving these targets, we will fundamentally improve the quality of education, training, and practice environments, and ultimately, the quality of care for patients. It will play a regular part in how we hold ourselves and others to account for progress and we hope it will be an ongoing catalyst for engagement and collaboration across the health service.

125. The first report demonstrated we had made a strong start. Workstreams had been established to lead and deliver the commitments supported by longer term plans. We had begun to engage with relevant system stakeholders on the priority issues to highlight what inclusive and fair environments look like. We changed our fitness to practise referral process, or when someone raises concerns about a doctor with us, so that we can better understand what local measures have been put in place to ensure referrals to us are fair. To improve fairness in education and training, we engaged with postgraduate training organisations, medical schools, and medical royal colleges to ensure they have equality, diversity and inclusion action plans in place to support these targets. We also implemented our own action plan to improve our own inclusivity.

126. The most recent update shows encouraging progress, but we recognise there is no room for complacency. At a time when the health service continues to face significant pressure it is vital that we, and all those with a role to play in tackling inequalities, maintain our focus and commitment. Our progress against the measures has seen:

    a. a consistent improvement for all fairer employer referrals measures, which is forecast to continue;

    b. some year-to-year improvement for four out of five education and training measures, with one measure indicating the difference in preparedness of F1 doctors, deteriorating. Data from some education initiatives we are piloting with other organisations show promising results;

    c. improvements in some inclusive employer measures, with a decline in others such as targets to appoint a higher percentage of ethnic minority candidates to management roles.

Our ways of working

127. Early in the pandemic, we established an internal recovery and renewal taskforce to ensure a coordinated and managed recovery of our paused activities. The taskforce oversaw the shift towards remote working and safely re-starting our on-site activities, including running the CAC and the shift towards virtual MPTS hearings.

128. Throughout our recovery phase, we conducted eight internal and external reviews [CM/29 – INQ000377434] of our response to the pandemic. The subjects of these reviews covered the operational aspects of the deployment of TER, our working arrangements, the shift to virtual hearings, and our overall governance and decision making.

129. The main conclusion of our reviews found that the GMC had considerable success in navigating the worst effects of the pandemic and that there were further opportunities for refinement. They also found that we needed to make sure that we understood our level of dependency, and the impact of clearing backlogs and project work, on the wider health system. In the event of a future emergency, this will help us ensure the right balance between delivering our statutory duties and responsibilities, while allowing our registrants to focus on providing frontline care.

130. Overall, we were able to adapt our processes to the extent that our existing legal framework would allow. The UK government's plans to reform professional healthcare regulation, including the legislation that underpins GMC's work, will enable us to benefit from even greater flexibility to respond to changing circumstances at pace.

Standards and guidance

131. Throughout the pandemic, we heard that professionals valued the benefits that arose from cross-regulator collaboration and partnership working with professional associations and other national and UK-wide organisations. This was especially apparent when we provided consistent, sometimes centralised, advice on applying professional and other national standards to emerging issues.

132. We built trust in the reliability of our advice by consulting key partners; publishing it our Covid-19 hub; acting quickly to publish new practical content on emerging

issues; and proactively issuing statements about how we would respond to complaints about not meeting professional standards. The Covid-19 hub received good feedback and engagement. Therefore, we would expect to take the same approach in any future national emergency.

133. The lessons we learnt from the pandemic, about the factors in healthcare environments that negatively impact staff wellbeing and workplace cultures, have significantly influenced how we have approached our review of *Good medical practice*. For example, evidence [CM/30 – INQ000346166] of the impact of bias and discrimination on health outcomes for patients, and career outcomes for doctors and other medical professionals, led us to prioritise and focus on supporting equality, diversity, and inclusion. We did this both in terms of how we ran the review, and in the key themes covered in the draft professional standards that we consulted on.

134. The pandemic also highlighted the importance and benefits of medical professionals working together effectively, often as part of multi-disciplinary teams. This features in our updated professional standards – along with other behaviours that underpin good professional relationships, including clear communication, and listening to and treating colleagues with compassion and kindness.

135. The updated version of *Good medical practice* was published in summer 2023 and comes into effect into effect on 30 January 2024.

136. We participated in MEAG which considered, at considerable pace, a wide range of emerging ethical concerns across the health and social care environment.[26]

137. We had anticipated that MEAG would update the existing ethical framework for pandemic influenza (2017), to address issues specific to Covid-19. We had also hoped that MEAG members would be able to make use of the meetings to explore some of the more complex or contentious issues raised directly with them by registrants or other groups. This might have provided an opportunity for members to reach a shared view and enhanced the quality of their organisation's response or provided greater confidence to those organisations about the robustness of their

[26] Further information about MEAG's work can be found on the DHSC's website.

analysis and conclusions. We did make a case for this to happen, with support from some other members. However, the DHSC were clear that MEAG's role could not be expanded in this way and that MEAG would remain focused on providing advice, as individual experts, responding to the urgent needs of the DHSC and the CMOs and Chief Nursing Officers across the four UK countries.

138. In the event of a future emergency, it would be helpful to establish a national ethics forum or coordinating body, either in each country or UK-wide, to facilitate more timely and consistent advice on ethical practice, and ideally on ethical concerns that cut across healthcare and other sectors. This forum could bring together relevant experts and provide a process for analysing and responding to complex or contentious ethical challenges as they emerge.

139. The remit of MEAG did not extend this far. However, we see a strong potential for a national ethics forum, supported by a national framework, to play a larger role in supporting consistent approaches to national and local decisions about resource prioritisation and allocation, to meet the competing needs of individuals and the wider population.

140. In normal circumstances, when developing guidance on ethical issues, or advice on the application of existing professional standards to complex new situations, we would engage with patient and public groups via in-person workshops or meetings. This was not possible, or was much more difficult to do, under pandemic conditions, which hampered our ability to hear diverse patient and public perspectives before producing advice on matters related to Covid-19. In the future, we would want to make greater use of digital platforms to enhance accessibility through online consultation.

TER and revalidation

141. We believe our temporary emergency powers are sufficient. The flexibility of the powers was vital in enabling us to respond quickly and appropriately to support the emergency response by granting TER to a large number of doctors who could be deployed within the heath service during the pandemic, and we did not face any legislative barriers.

142. The UK government's consultation Regulating healthcare professionals protecting the public (2021) [CM/31 – INQ000326300] proposes that all health and care regulators should receive emergency registration powers and, given the benefits that we have experienced, we agree that this should be included in future legislation to reform health and care professional regulators.

143. Once we began to grant TER, there were misunderstandings about which organisations in the system were responsible for managing the deployment of doctors. We received complaints and feedback from some doctors expressing disappointment and frustration that they were not being deployed. This was a constant theme of our engagement with doctors and other stakeholders throughout the pandemic and following every communication on TER. We signposted doctors to information about where and how they could be deployed and clarified that our role was to register doctors who could support the pandemic response and not to make decisions about which doctors were deployed where. It was also difficult to know how many doctors were deployed with TER, in what location and in what role, since we did not hold this data. In future, greater clarity is needed within health services about how they deploy health professionals who are granted TER.

144. Adopting either an opt-in or opt-out process for TER poses different challenges and benefits. Therefore, it remains essential to have the flexibility to decide which approach to adopt, depending on the specific nature of the emergency.

145. The pandemic accelerated our work on developing digital rather than in-person ID checks when registering doctors. We have successfully piloted a new app, and doctors are now being offered digital ID checks. At the time of writing, we are inviting those who registered earlier in the pandemic without an in-person check to complete theirs. We also adapted our registration process to receive applicants' documents electronically.

146. For revalidation, we have permanently extended the amount of notice we provide doctors that they have to complete their revalidation from four months to 12 months. This gives local healthcare providers more flexibility to plan and manage their clinical governance and appraisal systems. In 2022, as part of our work to reflect on the pandemic, we supported the Academy of Medical Royal Colleges to develop streamlined appraisal guidance and documentation, which included a

stronger emphasis on formative learning and reflection, quality rather than quantity of evidence, and a focus on wellbeing.

147. We also found it sufficient that doctors with TER do not have to participate in revalidation, although our expectation was that they should be engaged in local clinical governance and appraisal where possible. This is due to the nature of revalidation as a continuous regulatory process which is designed to provide ongoing assurance over time.

Medical education and training

148. The research we commissioned suggested that medical students who graduated in 2020 were better prepared for F1 because of the FiY1 intervention. Building on this learning, we want to expand the support for medical students as they prepare for their first roles. We also want these interventions to be flexible and adaptable to the needs of the systems in each of the UK's four countries, and to the specific roles medical graduates have at F1. We will consider proposals which seek to provide greater opportunities for medical graduates before they start their F1 programme, such as internships, on a case-by-case basis, making sure that they continue to meet our high standards and requirements. We are exploring enabling more flexible school leaver courses, enabled by the Medical Licensing Assessment (MLA),[27] to help support through-flow of students. We will also be reviewing our education outcomes at both undergraduate and foundation training level to ensure that they remain fit for doctors of the future.

149. Earlier in the pandemic, we also completed separate research on the preparedness of recent graduates to meet future need. A copy of this report is included at [CM/32 – INQ000362205]. Despite the additional complexity of undertaking their foundation programme training during a pandemic, graduates on the whole reported good levels of preparedness. This positive finding indicates that

[27] The MLA is a two-part test that will set a common threshold for safe medical practice in the UK. All medical students graduating from UK universities from the academic year 2024–2025 onwards will be required to pass the MLA as part of their degree before they can join the medical register. International doctors who want to practise in the UK and who currently take PLAB will need to take the MLA from 2024.

current undergraduate medical education provision is adequately preparing doctors for unforeseen changes in healthcare needs.

150. We believe that the exemptions for training we introduced with stakeholders were essential to the continued pipeline of doctors and the delivery of service in the immediate situation. Not putting these initiatives in place could have resulted in severe bottlenecks in the provision of service, with doctors who could safely deliver a service prevented from doing so because the pandemic pressures meant it was not possible to demonstrate competencies in the same way as prior to the pandemic.
151. Simultaneously, it was important to take a risk-based approach to ensure that patients were not put at risk, so we maintained the same standard and ensured that critical progression points were prioritised and that achieving completion on training was based on the same outcomes as before the pandemic.
152. We know that patients benefit significantly when doctors combine generalist and specialist capabilities. During the pandemic many doctors combined these skills by working across teams, specialties, and work contexts. The pandemic confirmed that we need flexible structures that give doctors both the specialist skills they need and the generalist skills to adapt, including the role doctors have in promoting practical, preventative public health.
153. This will enable doctors to get the right balance of skills to meet service and patient needs as they emerge throughout their careers. Our current *Outcomes for graduates* guidance already promotes this approach, and we will build on this as we begin to review the guidance in 2023.

Fitness to practise

154. The use of digital platforms for our fitness to practise processes was well received by complainants, doctors, patients, and the public. The relaxing of social distancing rules then allowed increased flexibility with the introduction of a hybrid model. This meant that, where appropriate, we could offer face-to-face appointments which helped us to take account of individual doctors' needs more effectively. We have largely retained the shift to virtual formats unless otherwise required.

155. The pandemic also provided us with an opportunity to review how we undertake performance assessments, which provide us with an independent opinion about a doctor's fitness to practise and standard of their professional performance as part of an investigation or tribunal hearing. During the pandemic, we streamlined the process, with short form assessments being adequate in most cases. This reduced the input needed from NHS organisations. We have since retained this approach, only doing site visits when necessary.

156. Our updated decision-making guidance [CM/33 – INQ000362211] enabled us to identify improvements to the way in which we describe how we take relevant context into account. We fed this learning into the review of our professional standards, and the updated introduction to the new edition of *Good medical practice* explains more clearly the relationship between the standards and fitness to practise decision making. It includes some explanation of the role that context plays in our consideration of whether a doctor poses a current and ongoing risk to the public.

157. The fitness to practise decision making guidance was well received by the profession and effectively supports decision makers in ensuring they take context into account. Although the specific pressures of the pandemic have reduced, its effects continue to be felt in terms of backlogs and increased waiting lists which means the medical profession continues to work under considerable pressure. In response to this, we have updated our procedures, and ask responsible officers to provide information about system pressures and factors affecting the working environment when they make a referral to us.

158. Our learning has also fed into our development of a new suite of decision-making guidance in preparation for regulating anaesthesia associates and physician associates and wider regulatory reform for doctors. We have developed content to provide clarity to doctors, patients, and stakeholders on what we mean by key fitness to practise concepts. This includes relevant context, such as the systems and interpersonal factors in the doctor's working environment, as well as their role and level of experience. We will publish some of this explanatory content alongside our revised professional standards.

159. Finally, we conducted an internal review of Covid-19 related cases in 2021 [CM/34 – INQ000377433]. We found systemic and contextual issues changed throughout the pandemic. For example, as the pandemic continued, some issues, such as availability and adequacy of PPE, became less pressing as supply and quality improved. Others, including the disproportionate impact of Covid-19 on people from BME communities, remained significant. New concerns, such as the impacts of widespread staff burnout, emerged as the long-term impacts of the stress on the system took hold. Although these issues evolved as the pandemic progressed, the principles set out in our decision-making guidance remained both relevant and applicable.

Closing statement

160. We would be very happy to discuss any of the information we have provided with the Inquiry, or provide any further information. We will continue to reflect on, and embed, the learning points we have as an organisation in collaboration with wider regulatory and system partners.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

Personal Data

Dated: 30 January 2024

Annex A

Table of exhibits: (34 exhibits)

	Date	Notes/ Description	Exhibit number
1.	June 2023	Data displaying the number of doctors with a licence to practise, by country and specialism as at March 1 2020.	CM/1 – INQ000362199
2.	June 2023	Table outlining the number of doctors we granted TER between March and April 2020.	CM/2 – INQ000362206
3.	April 2020	Policy statement on the removal of temporarily registered medical practitioners.	CM/3 – INQ000362207
4.	September 2022	Letter from Minister Jenrick to Charlie Massey	CM/4 – INQ000377431
5.	September 2023	Letter from Minister Quince to Charlie Massey	CM/5 – INQ000377432
6.	July 2015	Outcomes for provisionally registered doctors	CM/6 – INQ000326296
7.	July 2021	2020 Medical Graduates: The work and wellbeing of interim Report: Foundation Year 1 (FiY1) doctors' during COVID-19.	CM/7 – INQ000362208
8.	2018	Outcomes for graduates.	CM/8 – INQ000362203
9.	September 2021	Joint statement on temporary derogations in medical education and training.	CM/9 – INQ000362209
10.	2020	National Training Survey summary report.	CM/10 – INQ000362210
11.	September 2020	COVID-19: assessing the risk to public protection posed by a doctor as a result of concerns about their practice during the pandemic.	CM/11 – INQ000377427
12.	March 2013	Guidance: Doctor's use of social media	CM/12 – INQ000326299
13.	3 March 2020	Statement on how we will continue to regulate in light of novel coronavirus (Covid-19).	CM/13 – INQ000326301
14.	11 March 2020	Statement on supporting doctors in the event of a COVID-19 epidemic in the UK.	CM/14 – INQ000326302
15.	April 2013	Guidance: Good medical practice.	CM/15 – INQ000362200

16.	October 2021	GMC response to DHSC consultation on making vaccination against COVID-19 and influenza a condition of deployment in the health and wider social care sector.	CM/16 – INQ000362201
17.	10 February 2022	Joint statement from the GMC and Academy of Medical Royal Colleges on doctors' vaccination	CM/17 – INQ000356267
18.	April 2020 – February 2023	Advisory content on the Covid-19 Ethical Hub.	CM/18 – INQ000377428
19.	April 2021	Guidance: Good practice in prescribing and managing medicines and devices	CM/19 – INQ000356268
20.	September 2020	Guidance: Decision making and consent	CM/20 – INQ000346167
21.	May 2010	Guidance: Treatment and care towards the end of life	CM/21 – INQ000346168
22.	15 April 2020	Statement on advance care planning during the Covid-19 pandemic.	CM/22 – INQ000326295
23.	October 2022	Policy document: Advance care planning policy for adults in Northern Ireland	CM/23 – INQ000377426
24.	2020	Report: The state of medical education and practice in the UK	CM/24 – INQ000326297
25.	2021	Report: The state of medical education and practice in the UK	CM/25 – INQ000326298
26.	May 2020	Written evidence for the Women and Equalities Committee inquiry into 'Unequal impact: Coronavirus (Covid-19) and the impact on people with protected characteristics'.	CM/26 – INQ000362204
27.	2022	Report: Equality, diversity and inclusion: targets, progress and priorities for 2022	CM/27 – INQ000377429
28.	2023	Report: Equality, diversity and inclusion: targets, progress and priorities for 2023	CM/28 – INQ000377430
29.	September 2020 – November 2021	Various internal and external reviews of the GMC's response to the pandemic.	CM/29 – INQ000377434

30.	2022-2023	Equality analyses of the review of Good medical practice	CM/30 – INQ000346166
31.	2021	Consultation: UK Government – Regulating healthcare professionals, protecting the public	CM/31 – INQ000326300
32.	February 2022	Preparedness of recent medical graduate to meet anticipated healthcare needs report.	CM/32 – INQ000362205
33.	January 2022	COVID-19: assessing the risk to public protection posed by a doctor as a result of concerns about their practice during the pandemic (updated version).	CM/33 – INQ000362211
34.	2021	Paper: internal review of Covid-19 related fitness to practise cases.	CM/34 – INQ000377433