

EQUIVALENCE

**An introduction for new Committee Members Educational
Supervisors and Applicants**

**The Royal College of
Anaesthetists**



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1. The process for assessing equivalence of specialist qualifications to UK qualifications is demanding and detailed. This document is to introduce new Equivalence Committee members to the process but will be useful to educational supervisors and applicants.
2. The process was introduced by PMETB and came into force on September 30th 2005, with the old process being wound up in December 2005. Because of its relative newness; the process is still developing to some extent. This paper sets out the current position.

ENTRY TO THE UK SPECIALIST REGISTER (UKSR)

3. To clarify; the Certificate of Completion of Training (CCT) should be distinguished from Specialist Registration. The CCT and its European equivalents, marks the completion of an approved specialist training programme in an EEA state. It is just one means of entry to the UKSR (United Kingdom Specialist Register) which is a pre-requisite to be appointed to any substantive UK consultant post¹. There are three other routes to the UKSR:
 - a. For most, entry to the UKSR was automatic because they were established consultants when the register came into being. Since 1996 entry for UK specialist trainees has resulted from successful completion of specialist training and the award of a CCT (formerly CCST).
 - b. Any doctor with a **CCT** from an EEA country which has been acquired after primary and specialist training *completely undertaken in the EEA* has automatic right of access to the UKSR. For doctor's whose medical training has not been completed in the EEA, even if they are EEA citizens and have a non-UK CCT, they do not have automatic right of access to the UKSR. This is a European Court decision. Doctors who have gained entry to another EEA state's Specialist Register by their local version of Equivalence *do not have* automatic right of access to the UKSR. It should however be taken into account if provided as evidence in an application.
 - c. Doctors who do not meet the criteria in a and b for entry to the UKSR have to apply to the GMC by the Article 8 "Equivalence" route to obtain a Certificate of Eligibility for Specialist Registration (CESR).

WHAT IS EQUIVALENCE ASSESSMENT FOR?

4. Equivalence is the process by which applications from doctors defined above can apply for admission to the UKSR. Equivalence applicants usually fall into two groups:
 - those who have trained entirely abroad, and
 - Those who have had some of their training in the UK.
5. Of the latter group, some are working in UK when they apply, some not. Many of those working in the UK are in non-consultant career grades, some for many years, having had to stay at that level when their training and experience could not be recognised under the old Equivalence rules.

¹ This includes honorary posts, but not locum posts.

6. Some applicants, trained entirely abroad, have just completed that training; others may have been senior doctors and practising independently for decades. Some have been working as locum consultants in UK for years, some have never even been here. Each case is different.

THE PROCESS

7. Applications go to the GMC, where they are processed. In spite of extensive advice on the GMC website, many applications are incomplete when they are received, and further data are deemed necessary. For all applications, the GMC seeks references from 5-6 referees identified by the applicant. The referees must be medically qualified. Some referees decline to co-operate, actively or passively, some are deceased or otherwise un-contactable. Often applicants have to find alternative referees.
8. After an application is deemed complete, it is sent to the College for assessment by the Equivalence Committee; and a recommendation is made to the GMC for or against inclusion in the UKSR. Where the recommendation is against inclusion a recommendation is made for further training/experience and/or further evidence, which, once successfully complied with would make the applicant likely to pass equivalence.
9. At RCoA, we have a minimum of 3 evaluators for each case. We prepare by reading the application, considering it, and preparing a provisional decision on each component of the assessment which they discuss in committee. We believe this method is fairer, and gets round the difficulty of agreeing recommendations for further training etc where the outcome of the assessment is not agreed.
10. Where there have been four or more applicants, we have divided the committee into sub-groups to consider batches of applicants under an experienced chair. These groups then report to the committee as a whole, where difficulties may be discussed further and decisions reviewed. Where we have new committee members, they are asked to prepare the cases allocated to them – which may take 2-3 hours, more when the task is unfamiliar – and take full part in the discussions, as a learning exercise. It really is extremely important to have allocated the time to read the papers, as without that preparation, the exercise, and the costs involved, are wasted.
11. Note that the decision is legally the GMC's and they have review committees for QA, which look at whether the evidence College evaluators rely on supports the conclusions they draw. The review committee has the power to reverse the recommendations. GMC can ask for a recommendation to be strengthened or clarified before adopting it.

WHAT DOES THE APPLICANT HAVE TO DO TO PROVE EQUIVALENCE?

12. First, it should be clear that it is **up to the applicant to prove equivalence**, through evidence s/he submits plus references. There is no presumption of equivalence, or indeed of anything else, and everything may need evidential support. Evidence can be documents, references, and of course the applicant's own written evidence. Any one of these is unlikely to suffice by itself, as there will need to be triangulation of much of it for it to be convincing. Reaching Equivalence will permit the applicant admission to the UKSR, and thus to apply for UK consultant posts: the evaluators must therefore be sufficiently satisfied with the evidence to

be confident in the decision, as an exercise of professional judgment. Proof does not have to be beyond reasonable doubt. Something above balance of probabilities is probably right, but bearing in mind that negative information when it comes from an applicant or his/her selected referees is unusual enough to carry great weight.

13. Secondly, what **the applicant has to prove** is that s/he achieves **the appropriate standard in all the 4 domains of Good Medical Practice**. These are, briefly:
 - Knowledge Skills and Performance
 - Knowledge and Skill
 - Application of Knowledge and experience (e.g. CPD, Clinical governance)
 - Safety and Quality
 - Protect patients and improve care
 - Monitor and respond to risk
 - Communication, Partnership and teamwork
 - Effective communication with patients and colleagues
 - Leadership
 - Consent
 - Maintaining Trust
 - Respect
 - Fair treatment
 - Integrity and honesty
14. These have been summarised for simplicity: they can be found in full in GMC publications, (<http://www.gmc-uk.org/>), on the structured reference forms for equivalence applications, and on GMC's evaluation forms. Most evaluators view these domains as helpful in assessing applications. While it might seem unfair to assess equivalence applicants to a standard which UK doctors are not routinely assessed against, it is helpful to have criteria other than simple medical ability, especially for borderline applicants. Further, one cannot make assumptions about the culture of medicine outside the UK, and it is necessary to provide evidence that the applicant will come up to the relevant standards to work in the UK medical culture.
15. **What is the appropriate standard?** For Domain 1A, Knowledge and Skill, this is the standard of the recent CCT holder. While it is recognised that many existing consultants might not achieve that, especially where they have sub-specialised, and that there are several different routes to a CCT in Anaesthesia, this is a useful test. Where training has recently been completed, and there is a subspecialist element, we want to ensure that the applicant is at least generalist enough to have equivalent skills to those acquired during the ST5-7 generalist year. Where an applicant is clearly a generalist, we look for enough subspecialist skills as might arise from exposure to neuro, cardiac, paediatric anaesthesia to be able to manage the sorts of emergencies that might arise in a DGH, and would expect to see substantial obstetric and critical care ability, and skills to manage emergency anaesthesia and paediatric stabilisation before PICM transfer.
16. When it comes down to it, though, we have to be confident/satisfied that the applicant has the competences of a recent CCT holder who takes up a substantive post as an NHS consultant.

It should be recognised that the Equivalence process, as it now works, is intended to look at the outcome of training and experience, not just the details of training. Competences, especially ability to function as a consultant, are the thing, and as far as they can be assessed through a purely paper exercise, competences matter more than the route by which they have been achieved.

HOW IS EQUIVALENCE PROVED?

17. Training

- a. An applicant may prove equivalence through convincing evidence of recent completion of training in a system closely parallel to UK training. This evidence will need to prove duration of training, and appropriate content. The duration and content no longer need to match UK training precisely, but they will need to satisfy the committee that they will result in equivalent competences.
- b. Evidence of content of training may come from training documents from the relevant training scheme, from actual curricula, from exam documentation, and from statements from trainers and of course from statements from the applicant²: CV evidence, log books, and similar supporting statements can also contribute. Any one of these is unlikely to suffice by itself, but evidence that is internally consistent and triangulates with other submitted evidence can go a long way towards proving equivalence. Guidance on evidence that can be provided can be found in the Anaesthesia and General SSG guidance documents from the GMC.
- c. There are highly respected and recognised training schemes in some parts of the world that yet do not even vaguely match the UK training in duration or content. The best example of this is US residency programs, whose pattern is now followed in some other countries. Training lasts 3 years (after 1 year internship), and usually includes exposure to all sub-specialities, but not to the level we train to. This is because these systems are not intending to produce a fully competent independent consultant, and its product will usually be in a less responsible (“Junior Attending”) position initially, gaining experience with less challenging work and with close support until they can be completely independent. Some may take an extra year or two in fellowship posts gaining wider and deeper exposure to areas of anaesthesia or critical care they wish to practise in. The different duration and content of the US style residency program means it is very unusual for an applicant to be able to show equivalence as a result of such training alone. It is not unknown, the very brightest and most talented being able to achieve equivalence without further training or experience, but it certainly requires a high level of evidence from other sources than the residency program, and usually a fellowship period to broaden experience.
- d. Where we have limited or unhelpful evidence regarding training, or where we have positive evidence that the training undertaken does not match our standard, or was

² Be clear that evidence from an applicant should not automatically be discounted as biased. If triangulated externally and internally, it may contribute to the overall picture

not completed successfully, other evidence supplied will need to be a good deal stronger to satisfy the committee of equivalence.

- e. A note on Article 8(3)(b): Where an applicant has not had training/experience to match a recognised speciality, such as Anaesthesia, but has had training to NHS consultant level in an un-recognised speciality, perhaps such as cardiac anaesthesia & intensive care, they may be admitted under a different subsection of the governing order (see Appendix) which recognises that, since there is no CCT standard to achieve equivalence to, a different standard must apply. The applicant must satisfy GMC that his qualifications (competences acquired through training/experience): "...give him a level of knowledge and skill *consistent with practise as a consultant in the National Health Service.*" To be eligible for consideration under this article, the applicant must have had training in the speciality outside the UK, but otherwise the application is very similar to the normal one.

18. Test of Knowledge.

- a. Our Speciality Specific Guidance (SSG) regarding equivalence requires a test of knowledge. This will of course usually be by examination, and the UK, Irish, South African, Canadian or ANZ fellowships are all accepted. The Indian DNB is acceptable, as well as some of the Indian MDs, but because the MD in India is an internal university exam, and because we have evidence that standards differ substantially between different MDs, they are not all automatically acceptable. The Pakistan Fellowship is accepted as is the Sri Lanka MD, and a pass in the US State Board exam has been accepted (though "Board Eligible" status, which may be all some US senior doctors achieve, is not acceptable). There are undoubtedly other exams that will meet the criteria, and each will be assessed on the evidence supplied.
- b. It is theoretically possible that an applicant could prove s/he has the requisite knowledge without examination. However satisfactorily convincing evidence of knowledge without passing an appropriate exam would be difficult and time consuming to acquire, and it is difficult to think of a situation where it would not be easier to pass an exam: this will inevitably lead to the consideration of why an exam was not taken. So far, no applicant has attempted to gain equivalence based on a non-examination test of knowledge, though there have been applicants without any relevant exam, who have failed.

19. Experience

20. It is recognised that competences may be acquired through experience, and we are empowered to consider experience when evaluating equivalence. Experience can be evidenced through the CV, through structured references, through log-book data and through employment records, or any or all of them. (This is not intended to be an exhaustive list). Experience evidence can be used in various ways;
 - a. It may show that an applicant was exposed to a particular type of work which was not covered in training (or not at sufficient depth for equivalence), with sufficient supervision to make the experience virtually equivalent to training: some posts are not

recognised training posts, but may yet provide training, or the work may of necessity include training elements where an applicant has not been fully trained in some areas of responsibility, and competences need to be enhanced. This can, if appropriately evidenced, be accepted towards equivalence.

- b. Where an applicant's training record is incomplete, and it is unclear whether certain areas have been covered, evidence of subsequent safe independent practice to the appropriate standard in that area can be evidence that the applicant does have the necessary competences. Evidence of effective practice can be strong enough to be evidence of competence.
- c. Experience may similarly show that an applicant has acquired competences in a field through regular exposure in, for example, an SAS grade. In this way absence of actual exposure to neuro or cardiac anaesthesia may be overcome through experiential acquisition of the sub-specialist competences relevant to DGH practice, covering managing patients with sick hearts or damaged brains. There have been successful applications where there was satisfactorily strong evidence of competence in all required fields in spite of insufficient training.

21. Structured References.

- a. Structured references may provide evidence of the outcome of the sum of training and experience as no other evidence can. They may address competences directly rather than the process of (potential) acquisition of competences (training), and short of records of formal assessments, may be the only source of this type of evidence.
- b. Applicants are required to provide the names of 6 referees, who are required to complete structured reference forms answering questions relating to the fields of good medical practice set out above.
- c. A good structured reference can give a thorough and revealing picture of the applicant. This may show that the applicant is not (yet) up to the CCT/consultant standard, or may identify aspects of practice which are deficient. A good, thorough reference may also show that the applicant is fully up to the appropriate standard, with all the necessary competences and attributes. Structured references can therefore tip the balance where there is residual uncertainty about the applicant, and, where training (or the supporting evidence for it) is inadequate, can provide a very substantial proportion of the required evidence of the applicant's competences and attributes.
- d. On occasion, the applicant may only have one reference. Whether this results from inability to contact other referees because they've moved house or died, or because referees may be reluctant to support or openly to criticise the applicant, or for any reason, really, the absence of other references presents a problem. Currently the Equivalence Committee regards having only one reference as a fatal flaw in an application, and it has not recommended for inclusion anyone with one single reference. Whilst of course all cases must be considered on their merits, and it is therefore not impossible that an applicant with one single structured reference will be

recommended for admission, it is unlikely. Everyone can make mistakes, and there is always a risk that the single referee has got it wrong. With only one referee, there is no possibility of confirmation or triangulation between referees, and it will be very difficult to satisfy the requirements of equivalence without that.

- e. On occasion there are non-anaesthetist references, and they can clearly speak to non-technical matters. If there is only a single anaesthesia reference, once again this is likely to prove an insurmountable obstacle, as it has not been found sufficient to pass for Domain 1A where there is a single anaesthesia reference.
- f. On other occasions, there has clearly been collusion between referees. This is not permitted by the GMC's regulations, as references are confidential to GMC. On one occasion, in spite of this clear regulation, all 4 referees from one hospital met to confer and complete their references identically, and advised that they had done so. On other occasions, it has been clear from identical or very similar wording, fonts and/or grammatical errors, that the references are not independent. There may be innocent explanations for this, but this may also arise from deliberate intention to deceive: the Equivalence Committee has referred applicants to the GMC where there seemed clear evidence of fraud.
- g. Without fraud, the effect of collusion between referees is to reduce the effective number of references, as two or more identical references must be considered as one: if that results in there effectively being only a single reference, the application is almost bound to fail, as described above. Even where there are other admissible references, undeclared collusion between referees may seriously reduce their credibility, and this will have to be taken into account, perhaps seriously damaging the applicant's chances.
- h. You may know a referee. This does not disbar you from assessing the applicant in the way that knowing him/her would (see below), and if it means you can better assess the credibility of the reference through your knowledge of the referee, it may strengthen the equivalence process. Such knowledge therefore must not be excluded, in the interests of patients.
- i. Referees have to answer the question "In your experience of the applicant's clinical practice is the doctor safe to be practising independently as a consultant in their specialty in the NHS." Many referees will have no experience of the NHS, but their lack of comment should be considered as no evidence rather than counted against an applicant.

22. Curriculum Vitae.

- a. Whilst it is tempting to dismiss the CV as necessarily non-independent or even biased, it may contain information on training and experience that is not provided by other sources or at all. Clearly such evidence must be regarded with circumspection, as it may well be biased, but just as clearly it can and often must be taken into account. If there is reason to mistrust the CV, where for example it is contradicted by other, more trustworthy, evidence, then it may be necessary to exclude its evidence completely,

stating reasons; but where this is not the case, and there is no reason to disbelieve the CV, it is perfectly proper to consider its evidence, and use it in the overall assessment. Bear in mind, of course, that considering evidence, or taking it into account, does not necessarily mean accepting it.

23. **Log books:** Applicants are encouraged by the GMC to provide logbook data. Where these are undigested lists of cases, they are usually unhelpful, as there is seldom time to undertake the digestion ourselves. Where the logbooks are summarised and sufficiently complete, they may tell you the current and past caseloads, which may allow conclusions to be drawn about competences. Clearly there is an assumption that cases are being undertaken effectively underlying any such conclusion, but this may be deduced from other evidence, such as the references or employment record. **Log book evidence of clinical activity should address all areas of practice including Intensive Care Medicine, Acute and Chronic pain Medicine, and the sub specialities indicated in the curriculum. Please note that for Paediatric Anaesthesia the age and/or the date of birth of the patient is essential.** The degree of supervision is useful particularly when one is looking for competencies at a higher and advanced level of clinical practice.
24. **Employment record:** Those of us who have employed locums in our departments for any significant period come to know a good deal about the doctor, through direct interaction, reports from ODPs, theatre and ICU nurses, and trainees. We learn whether a doctor comes promptly when called in, whether s/he panics or takes command, whether s/he gives good or less good care, stays with patients post-operatively and so on. If we keep a doctor as a locum for many months, or, more so, if we re-employ someone as a locum that speaks strongly of our confidence in the doctor to perform at the level they are employed at. Where the employment record reveals these patterns, it may be strong evidence of competence, at least at that level of employment.
25. **Other documents:** Applicants often provide copies of their CPD certificates, copies of their departments teaching and audit meeting schedules, copies of their on-call rotas and so on. Clearly these sorts of documents may confirm CPD, teaching, audit, contribution to on-call, and may thus triangulate other evidence towards these points. Appraisal reports, if provided, may also provide evidence for many of the GMP domains.

HOW IS THE EVIDENCE ASSESSED?

26. The decision to recommend for inclusion in the UKSR is not taken lightly, nor should it be, bearing in mind the effect of such inclusion, and that the GMC, though formally having the decision making powers, will not normally reverse a recommendation to include.
27. Different types of evidence differ in their weight. Evidence which is clearly derived solely from the applicant, such as the CV, the application form, and letters, has the *potential* for bias, though unsurprisingly, since most applicants are committed, honest and upright healthcare professionals, normally this sort of evidence is supported by triangulation with other data and is entirely credible. Where there is independent evidence, for example from the structured references that the applicant is a proper, honourable professional, then this will of course allow one to place more weight on evidence derived solely from the applicant.

28. Equivalence does not, as I have indicated, have to be proved beyond reasonable doubt, nor should it. This is the standard of proof of guilt of a criminal offence, which is hardly applicable to the equivalence process.
29. Thankfully, there is no need for a statement as to the precise mathematical standard of proof, as it would probably be impossible to quantify much of the evidence in that way. However, we do need to bear in mind that the judgment is a professional one. We must be satisfied that the applicant's competences reach the appropriate standard, and are confident in our recommendation. Evidence that prevents such satisfaction, such confidence may be one item alone, or a whole range of thing, may be a piece of evidence that clearly shows a defect in the applicant or merely the absence of sufficient evidence to convince. The committee's decision, however, should be without fear (or favour), and even if we believe there could be an appeal against a recommendation, that should not influence us.

RECOMMENDATION FOR FURTHER TRAINING ETC..

30. If an applicant is not recommended for inclusion in the UKSR, the evaluators are required to make recommendations for further training or experience, or for further evidence to be supplied. Where it is unclear whether an applicant has competences, s/he may need more training/experience, or merely a credible assessment showing these competences to be present. Clearly absence of evidence is not evidence of absence, but where we do not know, we may make recommendations for robust, thorough assessment, whether after a further training period, further experience or freestanding. This type of recommendation recognises that freestanding assessments may be difficult to arrange, but that we would be happy to consider them if available. On occasion, an applicant has already had such assessment, but has failed to include it in the application: it could be considered on its merits later, if supplied.
31. Merely having further training is not, of course, sufficient. Training must be validated with assessment, which must of course be successful to the CCT standard. The GMC has on occasion asked for guidance on the form which assessment should take, and have been satisfied to be advised that it should be clinically based, whether from DOPS, CBD, A-CEX or MSF or all of those.
32. When applicants have successfully completed further training, experience or assessments, or acquire other evidence to complete their application, the process allows for review or reapplication, depending on applicable regulations. The re-consideration is undertaken by the Equivalence Committee, during its normal committee meetings.

WRITING THE REPORT

33. GMC provides an evaluation report form, some of which is pre-populated with data that will clearly have to be included. This includes a summary of training, qualifications and experience, which is completed by College staff.
34. A first draft of the report is written by College staff, it is reviewed by the committee chairman, and/or the chairman of the sub-group which considered the application, and then sent to the GMC. Extracts are also used for committee minutes for Council.

35. Bear in mind what the report is for: it will be read by the GMC officials of varying degrees of seniority and experience, may then be reviewed by a GMC review panel which will include two doctors and a lay person, none of whom may have any understanding of anaesthetic (or ICM) training, and potentially by the GMC Board. Any such report may also be disclosed to the applicant in litigation, and thus read by judges.
36. It is important, therefore, that we avoid use of any wording that might suggest prejudice, of any sort, and as far as possible phrase the report as a result of objective consideration and balanced judgment.
37. The report, because of the potential for judicial review, must not only clearly set out the decisions we recommend, but should also set out the evidence. Clearly this will not be the documents themselves, but page references and particularly relevant or convincing quotations. Any person reading the *report should* have access to the original application file, and thus page numbers will generally suffice. Where we have made decisions which balance conflicting evidence, this should also be clear in the report, and we should be able to say why we have preferred one side in such a conflict. This will not usually be resultant on the quantity of evidence but its quality. Such an assessment should be clearly set out in the report.

CONFLICTS OF INTEREST

38. Inevitably we will be asked to evaluate applicants that we know, or know of. If we know an applicant, we must make that clear as soon as possible – when we are asked to be one of the evaluators, at the beginning of the committee, or as soon as we realise. As we are required to have at least two independent evaluations of each applicant. This will allow the case to be transferred to another evaluator in time for him/her to assess it - it.
39. Where we know of people, this is a little more difficult, and potentially more damaging. If you know someone, perhaps well, your own evaluation may be flawed, but it is your own. Where you only know of someone, the evaluation is not even your own, but by hearsay and other un-testable evidence. I believe it is best to make such knowledge clear, and to avoid comment in committee.
40. Such conflicts of interest are minuted, and the minutes are of course open to scrutiny in the event of litigation.

EVIDENTIAL ANALYSIS FOR PARTICULAR DOMAINS OF GMP

41. **Good clinical care:**
 - a. As I have said above, we need evidence of reaching the standard of a CCT holder, or an existing consultant. Training, if the assessment is to rely very substantially on it, should follow roughly our pattern. It should meet our aim of a balanced programme, including a minimum exposure to essential specialities even if the overall aim is to become a generalist, and at least a minimum generalist training even if an intending subspecialist. Thus all would be expected to have competences equating to 12 months

generalist equivalent, and to cardiac, neuro, paediatric and obstetric anaesthesia higher training, intermediate acute and chronic pain medicine, and ICM to intermediate/Step 1 level, as set out in anaesthesia and ICM CCT documents. A sub-specialist pattern is of course acceptable, but should match these minimum requirements, unless it comes under Article 8(3)(b): which I have mentioned above.

- b. Training need not follow our pattern precisely, but the whole sum of it should be such that it would result in the same competences, if it is to be relied on as the major source of evidence.
- c. Where the evidence is that training has not matched ours closely enough, as I have said there may be reliance on evidence of experience, or of outcomes of the whole process.
- d. Domain 1 does not only consist of good clinical care, but includes elements relating to self awareness CPD, Teaching and training, and participation in clinical governance activities and audit.

e. ***Evidence***

- (i) Evidence may consist of records of training, including CV, curriculum, documentation of specialist areas covered in posts; formal assessments (RITAs, other outcome documentation), structured references or other statements from colleagues who have known the applicant (these must include his current MD, CD or equivalent, so cannot just be his/her friends); log book data showing range of current work, CPD where training etc completed long ago.
- (ii) Sometimes absence of evidence in one of above areas is not fatal, but we always need convincing positive evidence in this field. Complete absence of evidence in an essential component of may lead to failing Domain 1, as of course may negative evidence – ignorance of an essential area – or evidence of achievement only of non-consultant levels of responsibilities and ability.
- (iii) There must also be a test of knowledge, which the applicant must of course have passed. This might be FRCA, the Irish, SA Canadian or ANZCA equivalent, and these are easy to assess. Others that have been accepted include certain MDs from Sri Lanka, India, and Fellowship qualifications from Pakistan and other countries such as the US State Boards. It is even theoretically possible for knowledge to be proved without an exam, though clearly this will require a wealth of evidence to allow confidence of the standard achieved. Where we don't know the standard of a test (no curriculum or evidence of the required standard provided in the application, and we have no prior knowledge) we must reject it. This approach applies across the board: where evidence is insufficient to prove something, where a verdict would be “not proven”, we must decide against recommending inclusion under that heading.

42. **Relations with Patients:** Applicants must produce evidence that they reach appropriate standards, whether through comments in structured references or from grateful patients,

other colleagues, etc. This might fail where there is no positive evidence, or where negative evidence offered (shouts at Patients, ignores consent, for example). Most applicants have ample evidence under this domain, and it is unusual to fail it.

43. **CPD:** Applicants will need positive evidence of compliance with this requirement, which may be records of courses and meetings attended, comments in structured references, published works. If training/ experience was completed long ago, there may be specific needs that have to be complied with in CPD, to demonstrate continued updating where exposure within the workplace may be limited. For example this might include life support courses, or paediatric placements. Many applicants provide a wealth of data under this heading, but some have failed because of little CPD or evidence of lack of exposure to necessary areas, such as emergency anaesthesia, ICM, paediatrics, suggesting not competent to become a DGH consultant. A guide to the extent of CPD activity needed can be judged against that which is required by established consultants to revalidate their licence to practice. It would follow that CPD activity in the most recent 5 years would carry more weight.
44. **Teaching, Training, Appraising & Assessing:** Some evidence of teaching is required, and of ability in assessing etc as laid out. This ranges from lists of courses or tutorials taught, evidence of a teaching for trainers course, or comments from structured references and CVs. Many have plenty of evidence, some very little. Too little or none will fail the applicant, as even the least educationally inclined may be called on to present cases/teach in lists etc. Very little might not be fatal where an applicant excels in other areas.
45. **Working with Colleagues:** Statements in structured references, letters from colleagues, 360° assessments may all contribute to this assessment. Most can find good support, some cannot, some – lacking insight – get references from colleagues whose comments are largely or exclusively negative. The latter will cause failure, but a balanced view, setting positives against negatives, may allow inclusion against bad opinion particularly if other triangulating evidence can settle the dichotomy of views.
46. **Probity and Health:** There are usually no problems here, though sometimes it is clear, whether under this section or the previous one, that the applicant has problems of unassertiveness as regards pressure from colleagues. This may be sufficiently problematic to fail the applicant. Secondly, we have had applicants who have defrauded their employers, and others, whose applications themselves give rise to concerns about probity, perhaps necessitating referral to the GMC. More often responses are negative – especially from CD/MD in large hospitals – such as “nothing known against him/her”, or reporting comments from another consultant, which may suffice where the rest of the application is very satisfactory.

SUMMARY

47. We are making a recommendation for inclusion in the specialist register. We do not have to be convinced beyond reasonable doubt, or to some other quasi-legal sliding scale, but are making a professional judgment. It is a judgment of whether we are sufficiently confident or satisfied that the applicant has reached the appropriate standard, based on assessment of all the evidence. Of course, there may be an appeal, and a recommendation may come back if it

turns out that the applicant does not have crucial competences. If we have made our recommendation based on the evidence that will be our complete response to criticism.

48. It is important to remember that we are **not** saying the applicant is suitable to be appointed as a consultant, merely that from the documentary evidence provided, we are confident he reaches the standard of a new CCT holder. We are as confident as we can be, from documentary evidence, that s/he reaches a standard appropriate for *consideration* for appointment as a consultant.

Revised April 2010

Appendix 1 – Extract of Equivalence Legislation

Art 8 of the governing Order requires:

Specialists eligible for entry in the Specialist Register

8.—(1) Persons are eligible specialists for the purposes of article 7(1)(a) if they are exempt persons and hold a recognised specialist qualification granted outside the United Kingdom as specified in article 10.

(2) Subject to paragraph (4), a person (“S”) is an eligible specialist for the purposes of article 7(1)(a) if S does not fall within paragraph (1) but has—

- (a) undertaken specialist training; or
- (b) been awarded specialist qualifications,

in a recognised specialty and satisfies the Registrar that that specialist training is, or those qualifications are, or both when considered together are, equivalent to a CCT in the specialty in question.

(3) Subject to paragraph (4), a person (“T”) is an eligible specialist for the purposes of article 7(1)(a) if T does not fall within paragraph (1) but—

- (a) has—
 - (i) undertaken specialist training; or
 - (ii) been awarded specialist qualifications, outside the United Kingdom in a medical specialty which is not a recognised specialty; or
- (b) has knowledge of, or experience in, any medical specialty derived from academic or research work,

and the Registrar is satisfied that these give T a level of knowledge and skill consistent with practice as a consultant in any of the UK health services.

(4) If S or, as the case may be, T, is an exempt person and holds a specialist qualification which—

- (a) was granted otherwise than in a relevant European State, and
- (b) has not previously been accepted by a relevant European State as qualifying an exempt person to practise as a specialist in that State,

S is not an eligible specialist pursuant to paragraph (2) and T is not an eligible specialist pursuant to paragraph (3) unless the Registrar is satisfied that the specialist qualification is evidence of training that meets, or under Article 22(a) of the Directive is to be treated as meeting, the requirements of Article 25 of the Directive.

(5) If S or, as the case may be, T—

- (a) is an exempt person who holds a specialist qualification which—

- (i) was granted other than in a relevant European State; but
- (ii) has been accepted by a relevant European State, other than the United Kingdom, as
qualifying that person to practise as a specialist in that State; or
- (b) has acquired specialist medical experience or knowledge, wherever obtained,

the Registrar shall take account of that acceptance or of that experience or knowledge, when determining the adequacy of the training or qualifications under paragraph (2) or (3).

- (6) A person is also an eligible specialist for the purposes of article 7(1)(a) if that person—
- (a) was included in the specialist register maintained by the General Council under previous legislation;
 - (b) had been determined by the Registrar to be an eligible specialist for the purposes of previous legislation; or
 - (c) holds a Certificate of Completion of Specialist Training awarded under, or by virtue of, previous legislation.
- (7) In paragraphs (2) and (3), “specialist training” means specialist medical training that—
- (a) comprises theoretical and practical instruction in a post specifically designated as a training post;
 - (b) takes place in a university centre, a teaching hospital or other health establishment;
 - (c) is supervised by an appropriate authority or other body; and
 - (d) involves the personal participation of the person training to be a specialist in the activity
and in the responsibilities of the establishment concerned.