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The Changing Natures of the Medical Register: Doctors, Precarity, and Crisis

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Abstract

This article interrogates the relationship between registration, the professions, and modern crises, using the Medical Register as an illustration. We start by surveying briefly the history of the regulation of health workers in the United Kingdom to contextualise the mechanisms of registers and registration. Under the initial model of registration, one could be in or out of the 'principal list', and various routes enabled health practitioners to obtain full registration and its ensuing privileges. That model still influences ordinary understandings of registration, but the paper identifies other categories of registration emerging in the middle of the 20th century, starting with the international crisis of the Second World War and up until the recent coronavirus pandemic. Drawing on historical and contemporary work, we show that there are multiple ways one can be on the Register, with some more precarious than others. In turn, we debunk the idea of the Register as a document immune from political choices and instead shed light on the details of its intimate engagement with modern forms of governance.

Keywords

Registration, professions and professionalism, doctors, professional regulation, health law, sociolegal history

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Introduction: Tactically Deregistered

Since the enactment of the Medical Act 1858, the General Medical Council (GMC) has maintained a List of Registered Medical Practitioners (LRMP) (the Register, as it is often called), a publicly available roster of competent qualified medical practitioners in the United Kingdom. As per Section 15 of the 1858 Act, qualified doctors were required to pay a fee to get on the Register, on which they could be listed for life unless they were erased for any reason. For a rank-and-file doctor, making it to the Register was conclusive, the culmination of a process of elite education and mentoring. Erasure from the Register, on the other hand, is a disgrace and a source of profound embarrassment. In popular parlance, such a practitioner is 'struck off' the Register and is no longer eligible to practise medicine.

Despite public perception of the Register being a clear-cut affair, it is, in fact, a flexible instrument that can be used for political negotiation. In 1963, after over a century of requiring a one-time fee, the GMC, in the face of financial pressures, proposed the introduction of an annual retention fee for its members. Although this proposal was reluctantly accepted by the doctors' trades union, the British Medical Association (the BMA), the idea of having to pay an annual fee to stay on the Register was unwelcome to many doctors, who considered it as 'salt on wounds' (Stacey, 1989: 19), arguing that registration 'was for life' (Stacey, 1992: 41).

Indeed, the dispute was more than a petty financial squabble (Editorial, 1972a). Doctors had long been dissatisfied with the GMC, with debates at the BMA and in medical newsletters *Pulse* and *World of Medicine* noting that the Council was outdated and in need of radical reform. Many considered the GMC to be 'full of elderly men' (Stacey, 1989:19), completely unrepresentative, and out of touch with most medics' practice. Out of 46 members, only 11 were elected. The disquiet became a tangible crisis at a BMA meeting in 1970 when a 'no taxation without representation type resolution' was passed. Several practitioners (between 2000 and 4000, the exact number of which researchers do not agree on) (Marks, 1978; Stacey, 1989) refused to pay the annual retention fee. In doing so, doctors purposely exposed themselves to erasure from the Register. Being struck off the Register, they would not be able to work, with possibly dramatic consequences for the logistics and delivery of healthcare in the National Health Service (NHS). The Conservative Health Secretary, Keith Joseph, advised the GMC Registration Committee to erase the names of those who were not paying (Stacey, 1989: 20). The discontent of doctors, which was meant to remain 'in the family' (Editorial, 1972b; Stacey, 1989: 39–43), was now in the public spotlight, with registration being deployed as political leverage, and discussed in the media and in the House of Commons.

If erasure from the Register could be used politically as a tactical flashpoint, then why wouldn't the Register and registration itself? While the mass deregistration of doctors in response to annual retention fees encapsulates one form of crisis, the recent coronavirus pandemic, which placed immense demands on healthcare professionals and led to moves to recall certain workers back to the Register, is another example of a crisis. What remains constant across modern crises is the flexibility of the Register itself and its role in determining who is called upon to serve in times of crisis.

Modern Crises, Doctors, and Registration

Our paper stems from a query into the everyday modalities of registration. Provoked by Jess Smith and Sarah Keenan's invitation to generate a cluster of accounts of registration, documents, and bureaucracy as technologies of governance, we take the registration of health professionals as our illustrative category. We do this by interrogating the relationship between registration and the medical professions, but instead of mapping the everyday life of registration, we focus on how registration evolves through crisis junctures.

The term 'crisis' has moved from being monolithic, clearly and technically demarcated in the field of 17th century medicine, referring to a moment of 'choice between stark alternatives' (Koselleck and Richter, 2006: 386) to acquiring broader, flexible, metaphoric uses in the spheres of law and politics. Today, crisis is used in everyday language and the media as a 'catchword'; yet this does not mean it has lost its grip. It still carries a powerful rhetorical impact on world events and arouses the analysis and imagination of many.

A crisis can be seen as an event, such as in the phrase 'covid-19 is a crisis'. In our paper, crisis is a narrative tool that defines, demarcates, and frames things as events with a beginning and an end. As Roitman (2020) suggests, the concept of crisis determines what counts and does not count as a significant event in time, posing a comparative and normative problem, and to be inscribed as such in history: crisis compared to what? And to what effect?

Specifically, the time-bound framing of a crisis has an impact on further framings of crises. To illustrate, research by Bergeon et al. (2020) shows that since the 2000s, enhanced crisis concerns over terrorist risks have dominated organisational agendas in France (and in other European countries), leading to the prioritisation of issues of migrants, immigration, and refugees over issues of health and wellbeing. In turn, preparedness for security threats side-lined preparedness for pandemic and other public health threats. Lack of or insufficient preparedness, and claims to unpreparedness form a substantial part of the surprise ingredient to a crisis. This helps to approach the covid-19 pandemic as a health but also organisational crisis, in the sense that it took the state and related organisations somewhat by surprise, more than it might have otherwise. This background does not only help to explain the tensions in the United Kingdom's national response and organisational strategies to staff shortages that emerged right at the outset of the covid-19 pandemic. It also helps us contextualise various changes to the Register that have occurred since its inception. The Medical Register is one of the technologies that the government and other bodies have at their disposal to act in response to surprise, set priorities and, in turn, create and document preparedness. In the next pages we will tease out the surprise versus planned elements of changes to the Register in light of perceptions of crisis.

Crises of expertise and professionalism have occurred alongside major transformations in the professions themselves, including the precarisation of an increasingly diverse professional workforce, nationally and internationally (Francis, 2011; Sommerlad, 2008). Gender, race, and class have been key to these transformations (Sommerlad, 2008). Despite its role in the transformations of the professions, registration

has remained understudied as a bureaucratic and papered site of interest that makes these changes tangible. Research on the medical professions has documented how employment in the NHS (Linton, 2021) and fitness to practise referrals (Atewologun and Kline, 2019; Smith, 1994) sustain unfairness and discrimination. Historical research demonstrates amply how the creation of the Register sustained colonial racial and gender hierarchies in British medicine (Haynes, 2017; Stacey, 1992). Yet we discovered that little was known about how the processes of making incremental amendments to the Register and its pluralisation into multiple registers, have been reactive, lacked systematic planning, and participated in inequalities amongst doctors, and between doctors and other carers.

As one of the forms registers take, the list is considered as one of the foundational activities of modern societies (Belknap, 2004). For structural anthropologist Goody (1977), the list has a clear-cut beginning, precise end, and a boundary. The Medical Register used to look like such a unidimensional list with no flexibility or built-in preparedness for sudden change, yet our paper debunks this structural understanding. The Medical Register was formerly an annual publication, making updates relatively straightforward as names got added or removed every year, and it now has an online version updated daily. It takes the format of a single list, comprised of the names, any former names, gender and reference numbers of doctors, the year and place of doctors' primary medical degrees, and their status on the Register such as the date of their registration, entry on General Practice (GP) and Specialist registers, and later on, whether they hold a licence to practise.

The paper draws on historical and contemporary work to show that there are multiple ways one can be on the Register, with some more precarious than others. We start by surveying briefly the history of the regulation of health workers in the United Kingdom to contextualise the mechanisms of registers and registration. Under the initial model of registration, one could be in or out of the 'principal list', and various routes enabled health practitioners to obtain full registration and its ensuing privileges. That model still influences ordinary understandings of registration, but the paper identifies other categories of registration emerging in the middle of the 20th century, starting with the international crisis of the Second World War and up until the recent coronavirus pandemic.

In the face of crises, registration became something that can be temporarily handed over to registrants and then taken back, or handed provisionally pending the fulfilment of certain conditions, or attached to certain limitations. In other words, registration duplicates (or rather multiplies), and in turn becomes more flexible, instrumental, and precarious. These changes also made registration much less clear, complicating popular understandings of the Register as an 'on or off' affair, and providing additional discretionary authority to regulators seeking to use registration as a tool of governance. We trace the reasons why these forms of more precarious registration were conceived and have flourished to this day, especially in times of crisis. One explanation for the seamlessness of these changes can be the form of the Register itself (as it is 'just' a list of names), which makes it look innocuous whilst malleable and responsive to political choices. By engaging in a historical overview, we show how the terrain for change brought by the Coronavirus Act 2020's 'emergency registration' was readied by prior transformations of the Register, over the course of the 20th century. In turn, we address how and why

the multiplication of the Register has led to the fragilisation of some registered individuals. In addition, the paper suggests that the tool of emergency registration has been particularly telling of who is relied on to get on (or return to) the Register at short notice, and therefore revealing of who are those trusted to answer the call of duty. During World War II, facing an intensified demand for doctors, the GMC extended emergency registration to Jewish refugee doctors and overseas- qualified doctors primarily from British colonies. In 2020, facing a similar challenge, the GMC focused mainly on bringing back retired doctors onto the Register. Amongst other questions we can ask how else the Register could be opening at the peak of a health crisis. Finally, without arguing for medical exceptionalism, the paper shows that the Register modulates contemporary understandings of registration as a technique of governance and as a list within the history of documentation.

In the next section, we set the scene by examining the initial model of medical registration. We then turn to the multiplication of its format, using by way of illustrations four moments where a felt crisis provided impetus to alter the nature of the Medical Register. The first is the urgency to respond to staff shortages during the First and Second World Wars, including tapping into medical graduates from British colonies and abroad to fill gaps in the healthcare workforce. The impulse to negotiate the British Empire's relationship with the Commonwealth along with the imperatives of Britain's membership in the European Economic Community constitutes a second relevant moment eliciting changes to the Register. Pressures for rapid expansion of a competent medical labour force form a third crisis prompting changes to the Register. Our fourth and final illustration is the sense of urgency provoked by fears of a staff crisis at the start of the global pandemic along with the creation, in March 2020, of emergency registration to respond to the pandemic. Traversing these crises, the Register moves like an elastic band, opening and tightening on the basis of policy-makers choices. Yet, intriguingly and because of the language of crisis, these choices often get presented as inevitable. We will return later to this sense of inevitability, because in times of crisis it often acts as a key to the reasonable and legitimate (Mbembe and Roitman, 1995). We conclude by discussing the consequences of fragmented registration, and what this might mean for sociolegal histories of registration.

The Register

The Register is the centrepiece of the GMC's efforts to regulate medical practitioners in the United Kingdom. The GMC is currently empowered to maintain the Register under Section 2 of the Medical Act 1983. A bureaucratic instrument, the Register dates to the middle of the 19th century, when it was created after a series of political struggles over standards in the medical profession and specifically over the type of person who was entitled to call themselves a medical practitioner.

Medical regulation in the early 19th century was a plural affair, with 21 self-governing bodies offering qualifications to individuals who wished to practise medicine. This pluralism engendered jurisdictional disputes, with each of these bodies defending their own regulatory authority (Haynes, 2017: 10–11). Another key concern of early 19th-century reformers was the presence of 'quacks' and other 'unorthodox practitioners' such as homoeopaths and herbalists in the medical profession (Roberts, 2009: 46–47).

For many campaigners, the lack of minimum professional standards for medical practitioners was the cause of 'extreme concern', with the medical press castigating the public's ignorance and gullibility that led them to prefer charlatans over educated medical practitioners; their interventions contributed to the push for the establishment of professional self-regulation (Digby, 1994: 27).

The 1858 Medical Act was the culmination of decades of campaigns and marked a sea change from the earlier framework of overlapping authorities by establishing the GMC, which was legislatively empowered to establish and maintain a register of qualified medical professionals in England, Scotland, and Ireland (Section 15, Medical Act 1858). Universities and licensing bodies were required to transmit lists of qualified persons to the GMC, which would add their names to the Register upon the payment of the requisite fees (Section 15, Medical Act 1858).

Although campaigners failed in their attempts to criminalise 'quackery' (Digby, 1994; Porter, 1988, 1989; Roberts, 2009: 46–47), the 1858 Medical Act mandated registration for persons who wished to perform official functions (such as issuing death certificates) or who aimed to obtain positions in public employment that required medical qualifications (Maehle, 2020: 45). The Register, therefore, became the basis of the creation of the medical profession itself. It defined who would be eligible to take advantage of the privileges and protections of being a doctor. Over the years this recognition of the special status of doctors has been further encoded into the law since it is now a criminal offence for a person to falsely pretend to be registered as a medical professional or to possess a licence to practise medicine (Sections 49 and 49A, Medical Act 1983).

In order to register as a doctor, applicants need to demonstrate that they possess acceptable qualifications, knowledge of the English language, and the skills necessary to practise as a doctor (General Medical Council, 2022a). Graduates of medical schools outside the United Kingdom, the European Economic Area, or Switzerland are usually required to pass the Professional and Linguistics Assessments Board (PLAB) test (General Medical Council, 2022b). All applicants are also required to demonstrate their 'fitness to practise'; accordingly, they must include information about health conditions, cautions and convictions, fixed penalty notices, proceedings by a medical school or employer, and medical negligence claims, in their application for registration (General Medical Council, 2022c).

Medical graduates from UK universities or foreign-qualified doctors who have passed the PLAB test are eligible for provisional registration. Provisional registration, along with a licence to practise, allows doctors to begin the foundation programme, a two-year training programme for newly qualified doctors (General Medical Council, 2022d, 2022e). Those who have completed the first year of the foundation programme or foreign-qualified doctors who have passed the PLAB test are eligible to apply for full registration. Full registration with a licence to practise allows doctors to progress to the second year of the foundation programme or to work in unsupervised medical practice (General Medical Council, 2022f). After completing the foundation programme, doctors can choose to complete GP training or training in a chosen specialty (National Health Service, 2022b). Doctors working as consultants are required to hold full registration along with specialist registration and a licence to practise; general practitioners are required to be on the GP register (General Medical Council, 2022g).

These requirements for getting onto the Register are complemented by rules relating to the removal of names from the Register. One of the rationales for the creation of the GMC in 1858 was to ensure minimum professional standards. Therefore, it was authorised to strike the names of those who were 'convicted in England or Ireland of any Felony or Misdemeanour, or in Scotland of any Crime or Offence' or had been 'judged by the General Council to have been guilty of infamous Conduct in any professional Respect' from the Register (Section 29, Medical Act 1858). The current statute authorises the GMC to erase a practitioner's name from the Register if a Medical Practitioners Tribunal concludes that their fitness to practise is 'impaired' (Section 35D, Medical Act 1983). Impairment of fitness to practise can encompass misconduct, deficient professional performance, a criminal conviction, adverse physical or mental health, or lack of knowledge of the English language (Section 35C(2), Medical Act 1983).

On the face of it, therefore, there is a single medical Register, albeit with multiple pathways to get onto it, along with a relatively clear mechanism for the removal of names from the Register. Over the past century and a half, however, governmental responses to varied crises have revolved around the creation of separate lists or appendices that fragment the original Register and often weaken the professional privileges that are attached to being a doctor. In the rest of the paper, we examine four illustrations of such fragmentation, starting with the Colonial and Foreign Lists used for overseas medical graduates.

The Colonial and Foreign Lists

The late 19th century was, in the words of Hobsbawm (1987), the 'age of empire'. The Register was also closely linked to Britain's imperial interests, with Douglas Haynes describing it as a 'gateway to the empire' because of the connection between the possession of a medical qualification and employment in colonial territories (Haynes, 2017: 15). One of the foremost controversies after the GMC was empowered to control entry into the medical profession through the maintenance of the Register related to the treatment of graduates of overseas universities. While any medical graduate of a university in the United Kingdom was entitled to be registered, graduates of foreign universities had to produce a degree of Doctor in Medicine and have been practising as physicians in the United Kingdom prior to the passage of the 1858 statute to be eligible to be registered (Schedule A, Medical Act 1858). By placing such limits on the ability to enter the Register, the GMC all but eliminated nonwhite colonial subjects from practising medicine in the United Kingdom since only a relatively privileged minority who could afford education in the metropole were able to meet this requirement (Haynes, 2017: 16–19).

Initial attempts to enable overseas medical graduates to practise in the United Kingdom without having to undergo requalification failed due to lobbying by the GMC, which was keen to preserve its authority to control admissions to the Register, and the BMA, which was interested in preserving the ability of British medical graduates to practise across the empire (Haynes, 2017: 19–23). In 1886, the Medical Act was finally amended to permit overseas-trained doctors access to the Register if their own jurisdiction allowed reciprocal access for British medical graduates. Their names were, however, placed on the separate Colonial and Foreign Lists. Registration on the

Colonial List depended on the doctor having trained in the colonies in medical schools founded by British doctors, delivering education in English, and inspected during informal visits by senior British doctors (Stacey, 1992: 46), and registration on the Foreign List was open to graduates of medical schools from countries that had reciprocity agreements. By 1914, the United Kingdom had reciprocity agreements with Italy, Japan, Belgium, Ceylon, Hong Kong, India, Malta, New Zealand, Newfoundland, the Straits Settlements, and several states and provinces of Australia and Canada (Haynes, 2017: 38).

These foreign and colonial medical graduates became particularly significant in combating shortages of medical professionals during the First World War, upending the GMC, BMA, and Medical Practitioners' Union's concerns about overseas professionals limiting opportunities for local doctors in the domestic market (Haynes, 2017: 36–37; Weindling, 2009: 2). After the war, however, dominions such as New Zealand and Canada began to challenge the primacy of the Register by disputing the GMC's interpretation of the scope of reciprocity arrangements. In the Council's view, all doctors on the Register, including those on the Foreign and Colonial Lists, were entitled to practise medicine in any country with which Britain had a reciprocity arrangement. Therefore, an Indian medical graduate who was on the Colonial List would be permitted to use reciprocity arrangements to be included onto the medical register in New Zealand. In the background of increasing demands for dominion autonomy in the interwar period, Canada and New Zealand sought to limit reciprocity only to those who had graduated from British universities. They therefore attempted to exclude doctors on the Foreign and Colonial Lists from relying on reciprocity provisions to get onto the dominions' medical registers, an effort in which they were ultimately successful (Haynes, 2017: 63–68). Despite being on the Register, therefore, those on the Foreign and Colonial Lists did not ultimately have the same rights to practise medicine across the empire as those practitioners who had qualified from British universities and whose names were part of the 'regular' Register. The separation of these lists ultimately led to the fragmentation of the Register, with practitioners' rights differing based on where they had obtained their qualifications.

The Register was further fragmented by the GMC's decisions in response to the crisis in Europe in the 1930s. Anxieties about competition from overseas doctors increased in the aftermath of the depression (Weindling, 1991) and were exacerbated by calls to accommodate Jewish refugees fleeing persecution in Nazi Germany (Haynes, 2017: 80). The BMA successfully lobbied against the British government's plan to bring over 500 doctors fleeing the war, reducing the numbers to 50 (Berghahn, 2007: 83). Such refugees were ultimately permitted to requalify but their right to practise medicine remained constrained by immigration restrictions. Specifically, the Home Office often required refugees to live and work in particular areas; these limitations were often endorsed by organisations such as the BMA (Haynes, 2017: 85–86). Immigration status, therefore, undercut the registration status of these refugee doctors.

In the face of labour shortages after the outbreak of the Second World War, policymakers created the category of 'temporary registration' to enable overseas-qualified doctors to practise medicine for the duration of the war, thereby dramatically expanding the available medical workforce. The GMC was empowered to add certain overseas-

qualified doctors to the Register for the duration of the 'emergency', first through Defence Regulation 32B, and later through the Medical (Temporary Registration) Order of 1940. Although temporary registration was initially limited to nationals of specific countries (Haynes, 2017: 81, 89–91), the list of specified territories was soon deleted altogether, allowing for the temporary registration of doctors from any foreign country (Decker, 2003: 865). Since Nazi laws stripped Jews of their right to practise medicine, Jewish refugees were unable to satisfy the condition that they were entitled to practise medicine in the country that they qualified (Haynes, 2017: 92). Therefore, the law was amended to enable registration if applicants could demonstrate that they had passed qualifying exams. Temporary registration was, however, restricted in scope. Initially, successful applicants were not permitted to engage in private practice but were primarily employed in local authority hospitals and the Emergency Medical Service; later, after acute shortages caused by British physicians being deployed in the military, foreign doctors were permitted to assist British doctors in private practice (Decker, 2003: 865–866).

By the end of the Second World War, there existed a maze of registrations: full registration for graduates of British universities, registration on the Colonial or Foreign lists for graduates of overseas universities, and temporary registration of overseas-qualified doctors from countries that did not have reciprocity arrangements. The ability of registrants to practise medicine was dependent on their type of registration, with different categories being subjected to different limitations. Despite the existence of a singular Register, therefore, the GMC's policies in response to the crisis of war had resulted in the multiplication of medical registrations in the United Kingdom, which continued in the postwar period.

Temporary Registration, Perennial Workforce Needs, and the Hierarchisation of Registers

Although temporary registration had initially been a proposal to combat labour shortages during the war, the Home Office moved towards permitting foreign doctors to continue to practise in Britain even after the end of the war, partly since political conditions meant that refugees could not be repatriated (Haynes, 2017: 97). The 1948 Medical Practitioners and Pharmacists Act formalised the process of temporary registration, broadening the GMC's power to register foreign and colonial doctors from countries outside the scope of reciprocity. However, such registration was restricted to those who intended to remain in Britain 'temporarily', thereby reinforcing 'the conditional nature of the presence of foreign and Commonwealth doctors in the United Kingdom' (Haynes, 2017: 99–100).

The creation of the NHS in 1948 further exacerbated the need for foreign health practitioners. As Margaret Stacey notes, these manpower needs became linked with registration requirements (1992: 46). Temporary registration of foreign medical graduates became critical for ensuring the availability of sufficient doctors to staff the universal health service. Since these doctors worked in 'underserved urban and rural hospitals' and under the supervision of a senior British member of staff, they 'would not compete with domestic medical graduates who pursued career advancement in the service or practiced medicine privately' (Haynes, 2017: 106). Although present in significant numbers

and critical for the NHS, overseas-qualified doctors were not organised and did not have a coherent voice. Despite their advanced qualifications, many of them were exploited in lower-level positions as a 'pair of hands' to staff inner city hospitals and rural areas, and bound to hold serial junior appointments or relegated to less prestigious and unpopular subfields and consultancies (Decker, 2003; Kriyakides and Virdee, 2003; Kushnik, 1988). This 'special' type of labour for foreign-trained doctors (Simpson et al., 2016: 215) was accompanied by a panoply of special forms of registration.

After the Second World War, there existed three registration paths for overseas-qualified doctors in the United Kingdom. The first route involved requalification and required overseas-qualified doctors to obtain additional degrees in the United Kingdom to apply for full registration. Under the second route, doctors who had qualified under the reciprocity arrangements could apply for full registration, provided the GMC was satisfied that they had clinical experience equivalent to what they would have got during their preregistration year if trained in the United Kingdom (Stacey, 1992: 47). The third path was temporary registration, which only permitted doctors to work in the United Kingdom for a period of five years. This was the only mechanism available to doctors from countries that did not have reciprocity agreements with the United Kingdom.

The fragmented nature of the Register, which resulted in temporal limitations being imposed by the GMC on temporary registrants, became the focus of controversy during the 1960s. Members of the public and medical professionals began to question why doctors graduating from countries with reciprocity arrangements could obtain full registration while those from other foreign countries were limited to temporary registration. Since reciprocity-granted countries included those from the Commonwealth (with South Asian doctors forming a bulk of the intake) while European doctors were limited to temporary registration, Douglas Haynes argues that the question became linked to broader debates about nonwhite immigration to the United Kingdom (Haynes, 2017: 127–138). Roberta Bivins has traced how, despite the rhetoric of the NHS being for 'everyone', there were 'accusations that immigrants in particular burdened and exploited the NHS' (Bivins, 2017: 93). In this context, the NHS revealed itself as 'both a site of antimigrant agitation and an institution heavily reliant on migrant labour' (Fitzgerald et al., 2020: 1163).

Some of this antimigrant sentiment was captured in the numerous complaints about the capabilities of migrant medical professionals. The bulk of the critique was that the GMC was registering doctors not appropriately qualified, and failed to register those who were (Stacey, 1992: 126). Concerns were raised about the language capabilities of overseas doctors along with claims that they might be 'insufficiently familiar with the particular circumstances of medical treatment in Britain' (Stacey, 1989: 18) The antimigration climate of British media amplified British doctors' complaints of 'cultural incompetence' and 'substandard' medical and communication skills of their overseas trained colleagues (Dewachi, 2017: 69).

These sustained critiques of nonwhite medical professionals led to reforms of the registration system. In 1969, the 'temporariness' element of temporary registration was removed and those who applied no longer needed to say they intended to leave the country after a definite period. However, such doctors could only obtain full registration

if they completed a clinical attachment of 12 months at an approved hospital and submitted a testimonial of their professional and linguistic capacity. Doctors from reciprocating countries, on the other hand, faced no limitations on their ability to practise, resulting in continued distinctions between how doctors from different countries were treated (Haynes, 2017: 135–136).

In 1971, a special committee of the GMC was tasked with reviewing arrangements for the registration of overseas doctors (Stacey, 1989). The committee's interim report acknowledged concerns about the language skills of overseas doctors and recommended the abolition of both reciprocity arrangements and temporary registration. Instead, it sought to introduce a new category of 'limited registration' for overseas graduates, which they could convert to full registration upon the completion of an examination and satisfactory service. Reactions were mixed, with some arguing that the system of limited registration might trap overseas doctors in junior positions. The potential political implications of these tests also became clear to British government officials, who were concerned that the imposition of an English-language requirement would complicate Britain's negotiations to enter the European Economic Community (EEC), given its effect on the mutual recognition of medical qualifications (Haynes, 2017: 146, 154–155, 174–176).

The overseas committee was also asked to complete a review of medical qualifications granted by schools in reciprocating countries. Although it recommended that qualifications from countries such as Australia, Canada, Hong Kong, Malaysia, and the West Indies continue to be recognised, it recommended the withdrawal of recognition from medical schools in India. This move would enable the GMC to impose conditions such as the successful passing of an assessment of clinical and language skills on Indian medical graduates without breaching the country-level reciprocity arrangements (Haynes, 2017: 170–173, 186–187). Given that the largest proportion of overseas-qualified doctors in the United Kingdom came from India, the decision would have significant consequences on the medical workforce. The final decision on Indian medical schools was, therefore, only taken after the submission of the report of the Merrison Committee.

The Merrison Committee was a public inquiry appointed by the British government amidst the public fallout of the growing dispute over the annual retention fee charged by the GMC. Its remit, however, was much broader, and encompassed a range of issues relating to the regulation of the medical profession, including the question of registration of overseas doctors. The Committee was chaired by Alexander Merrison, a particle physicist and the vice chancellor of the University of Bristol, and had no overseas trained or non-British doctor in its rank. Committee members linked professional regulation to public safety and considered its work to be 'to restore confidence in British medicine by clarifying membership within its boundaries chiefly through modifying the system of registration' (Haynes, 2017: 173, 191–192).

The report of the Committee devoted an entire chapter to overseas doctors and the problem of 'external labour'. The Committee noted that NHS and other evidence demonstrated the overseas doctor's 'lower level of professional knowledge and skill' than 'his counterpart educated in the British Isles' and pointed to additional difficulties of the overseas-trained doctor related to 'his (sic) understanding of patients and grasp of the language, attitudes, values, and conventions of the community in which he practices'. To

Alexander Merrison and his colleagues, even if the overseas doctor was 'fully knowledgeable and articulate in the professional field, his difficulty in communicating with patients in nonmedical terms may constitute a major barrier to his integration into medical practice in this country' (Merrison Committee, 1975: paras 185–186).

Although the Committee claimed that it would not 'judge the ethics of a service which relies on a substantial supply of doctors from countries which are themselves seriously short of medical services' (para 185), it was critical of what it saw as the GMC's 'undue complaisance in the face of NHS manpower needs' (para 192). The result was a series of recommendations that expanded the GMC's authority to regulate overseas doctors. The report deployed differentiated understandings of doctors' education and fitness to practise, with uneven impacts on the registration of overseas-trained doctors. The Committee concluded that a doctor's professional knowledge and training by itself was insufficient if there was a limited understanding of language and cultural values and attitudes of the broader community (Kyriakides and Virdee, 2003: 294). Therefore, it appeared keen to encourage the GMC to consider tightening its scrutiny to avert entry to the Register by overseas doctors who may not understand fine colloquialisms of a particular region or community. In the case of overseas doctors' registration, enlarging the remit of the GMC seemed appropriate. Yet when it came to regulating fitness to practise more generally, the Merrison Committee did not support expanding the GMC ambit to make it a 'patients ombudsman', because to do so 'would disperse efforts from taking action only when the right to practice is at stake, in cases where the doctor's conduct or condition poses a *public risk*'. It expressed resistance to the idea of the GMC scrutinising 'every aspect of doctors' professional dealings' (para 186). It was only the 'problem' of overseas doctors' fitness to practise that required additional powers for the GMC, leading to changes to registration requirements. The 'crisis' of public confidence in Britain's medical professionals was, therefore, linked specifically to overseas-trained healthcare workers.

The Committee also endorsed the GMC's view that temporary registration be replaced by limited registration, in which overseas doctors would be required to pass the Temporary Registration Assessment Board (TRAB) test. Full registration would be limited to 'distinguished' overseas doctors at the GMC's discretion rather than by reciprocity, which the Committee considered to be the reason for subversion of standards in British medicine (Haynes, 2017: 196). The Committee also proposed restrictions on recognition as a route to full registration. Just as the Merrison Committee was handing over these powers to the GMC, the GMC was facing reduction to its sovereignty in light of new European Community rules on the free movement of labour, which enabled European doctors to access full registration, without having to pass tests.

A month after the publication of the Merrison Committee report, the GMC accepted the overseas committee's recommendation to withdraw recognition of Indian medical schools; Haynes argues that the critiques of overseas doctors by the Merrison Committee provided additional support for this decision. Coupled with the termination of Pakistan's reciprocity agreement after it left the Commonwealth in 1971, this marked a major change in the registration requirements of overseas doctors since these countries supplied a bulk of the foreign doctors in the United Kingdom. As a result of

these withdrawals, medical graduates from India and Pakistan would have to pass the TRAB test and only be eligible for temporary registration (Haynes, 2017: 187–188, 198).

Reciprocity itself came to an end in 1980, with all overseas doctors being required to pass the PLAB test, which replaced the TRAB exam. By then, new British universities produced more domestic graduates coming to the market, and fears of 'medical unemployment' were expressed in the medical establishment (Stacey, 1992: 134). The GMC, which technically has 'nothing to do with manpower' had responded to the market demands to employ UK registered practitioners with practical measures on registration (Stacey, 1992: 134). For instance, Stacey noted how PLAB exams pass rates fluctuated (129): from 34% in 1975, it rose to 43% and then fell to an all-time low in 1985, then to rise again (135), thus providing further signs that overseas doctors' registration is linked to broader political tensions and market objectives.

Even after passing the PLAB, the right of these doctors to practise medicine remained subject to restrictions on length of time and place of practice. The GMC was granted the power to specify these restrictions for doctors who were admitted in the category of limited registration, with full registration being restricted to those overseas doctors who had the necessary medical qualifications and clinical experience. The flexibility of the Register, with its multiple types of registration, was key to entrenching hierarchies within the medical profession. Haynes argues that the 1978 Medical Act formalised 'a globalised medical profession that was stratified between domestic and overseas graduates, one largely white and permanent and the other largely nonwhite and transient' (Haynes, 2017: 202). These differences between the career progression of UK and overseas medical graduates continues to the present day, as seen in the next section on the creation of new positions as a response to workforce needs.

Further Attenuations: The Case of Speciality and Specialist Doctors and Locally Employed Doctors

A substantial proportion of the UK's licensed doctors (approximately one-fifth) are not on either the specialist register or the GP register. They are also not in training. This diverse group comprises Speciality and Specialist (SAS) doctors and Locally Employed (LE) doctors (General Medical Council, 2019: 4). Although these positions were created to create a more 'flexible' workforce, it is these very flexibilities that have engendered the establishment of newer forms of hierarchy within the medical profession.

SAS doctors are senior doctors in permanent posts and provide specialist clinical services (British Medical Association, 2022). They are often experienced clinicians who have ambitions to remain in their positions in contrast with LE positions covering a range of contracts that are often fixed term. Many (but not all) work as LE doctors shortly after completing their formal training and return to specialist or GP training or move to SAS contracts (General Medical Council, 2020a: 3).

Specific types of professionals tend to become SAS and LE doctors. A recent GMC working paper concludes that the broad category includes doctors who choose to spend their career on neither the GP or specialist register, doctors who are taking a break to build experience to get into the specialist training of their choice, doctors who work as locum doctors (to cover for other doctors on a part-time basis), and international

graduates participating in time-limited programmes (such as the Medical Training Initiative) following which they return to their home country (General Medical Council, 2019: 4). In recent years, an increasing number of doctors have chosen to become SAS doctors (British Medical Association, 2014: 2). SAS doctor positions offer some advantages: the opportunity to be more involved in direct patient care (compared with consultant or GP positions), work more regular hours and optimise work-life balance, and work in chosen geographical regions without having to rotate to different units. Many doctors also use SAS positions to gain experience in order to apply for specialty training or to have more time to study for membership exams (National Health Service, 2022a).

Despite the apparent advantages and flexibility of the SAS path, 31% of employers in a 2019 survey reported difficulties in the retention of SAS doctors. Common reasons cited by SAS doctors for leaving include career progression, pay, morale, and career development (Health Education England and NHS Improvement, 2019: 10). SAS doctors have reported that they are not often provided with 'the basics of good employment practice', including 'an appropriate induction, support with revalidation, a job plan, and job practice' (Health Education England and NHS Improvement, 2019: 8). They also 'struggle to access learning and development opportunities, specifically in comparison to consultant colleagues or doctors in formal training programmes'; this is partly because they have 'limited time to access opportunities because of their vital role in managing service pressures' (Health Education England and NHS Improvement, 2019: 12). SAS and LE doctors were more likely to be redeployed during the coronavirus pandemic and surveys have indicated their concern that 'they are becoming deskilled and that their career progression will be impeded' (General Medical Council, 2021a: 34).

Career progression for SAS doctors has historically been limited. In 2021, the NHS created a new specialist grade that sits between the specialty doctor and consultant grades. Those in specialist grade positions will continue to 'focus on providing direct clinical care but will also have further development opportunities such as management, additional responsibilities, research, and clinical academia' (National Health Service, 2022a). SAS doctors can also move into consultant posts but the application process is difficult and only 27% of SAS doctors have indicated any interest in applying for such certification (Health Education England and NHS Improvement, 2019: 12, 15).

In addition to difficulties in career progression, SAS and LE doctors also face a hostile work environment. A recent GMC survey revealed that 30% of SAS doctors and 23% of LE doctors suffered in their workplace from bullying, undermining, or harassment by colleagues, patients, and their families (General Medical Council, 2020a: 17). Research has indicated that SAS doctors often feel 'systematically undermined and believed their treatment was linked to a lack of respect for the grade' (Health Education England and NHS Improvement, 2019: 8).

These problems have a disproportionate effect on overseas-trained medical professionals. Over half of SAS and LE doctors possess a primary medical qualification from outside the United Kingdom, the European Economic Area (EEA) and Switzerland, with a higher proportion of international medical graduates working as SAS or LE doctors in comparison with those on the specialist or GP register (General

Medical Council, 2021a: 8). To compare, only 25.7% of the entire licensed UK doctor population have a primary medical qualification from outside the United Kingdom or the EEA (General Medical Council, 2020a: 6). Data from the GMC indicates that between 2014 and 2021, an increasing proportion of EEA graduates coming to the United Kingdom become SAS and LE doctors, rather than join the specialist or GP registers. Only 3–6% of them progress on to the specialist register within two years (General Medical Council, 2021a: 85). Furthermore, the region of Europe from which graduates come from has an impact on the likelihood of the type of register they will join, with graduates from Eastern Europe more likely to join the SAS and LE registers than graduates of Northern and Southern Europe (General Medical Council, 2021a: 85).

These patterns suggest persisting hierarchies between international medical graduates based on the countries where they train. The hierarchies are reproduced amongst UK graduates as well since data from 2018 indicates that about half of SAS and LE doctors have a Black, Asian, and Minority Ethnic (BAME) background, with only one in three being white (the rest have no recorded ethnicity) (General Medical Council, 2019: 8). This make-up of the SAS workforce also has implications for the support that is required for them since BAME and international graduates are consistently more likely to be referred to the GMC for fitness to practise proceedings (Atewologun and Kline, 2019: 3; Health Education England and NHS Improvement, 2019: 6–7). Hierarchies also affect the nature of the opportunities available to groups within the broader class of SAS and LE doctors. In comparison with SAS doctors holding a UK medical qualification, a greater proportion of European and international medical graduates have reported that they had not been assigned an SAS tutor and that they felt that they did not have the information necessary to access the guidance and opportunities available to them (General Medical Council, 2020a: 22). Out of those EEA graduates who join the SAS and LE registers, only a low proportion use it as a springboard to access the specialist register (General Medical Council, 2021a: 85).

Research in sociology by Beagan (2001) has noted how hegemonic professionalism in medicine resists institutional commitments to equality and the implementation of antidiscrimination policies. The processes of registration have proved no more efficient in bringing equality. In fact, as this section has demonstrated, the multiplication of the Register has sustained entrenched inequalities within the profession. The advent of nontraditional cohorts of students in universities, composed of BAME and working-class students, has the potential to make the profession more diverse. However, as has been observed in the legal profession (e.g. Sommerlad, 2008) the potential for a more diverse medical professional workforce is eroded by ongoing stratification within the medical profession. The roles of SAS and LE doctors, with their separate, different lists, show further fragmentation of the Register, and in turn that fragmented Register reproduces familiar hierarchies based on race, citizenship, and class, similar to those observed for gender: the predominance of nontraditional entrants in the profession risks creating fields and subfields that become devalued, less prestigious and less well paid (Waugh et al., 2019: 199). For our last illustration, we turn to the coronavirus pandemic, as this global crisis prompted the rapid creation of yet another separate register.

The 2020 Pandemic Register

In March 2020, as part of the governmental response to the coronavirus pandemic, the GMC extended temporary emergency registration to retired doctors (General Medical Council, 2020b, 2020c). During an emergency 'involving loss of human life or human illness', the GMC is empowered to register 'subject to such conditions as the Registrar may specify', any 'fit, proper and suitably experienced person' as 'a fully registered medical practitioner' (Section 18A, Medical Act 1983). Initially, doctors who had given up their registration in the previous three years were registered; this was later extended to doctors who had given up their registrations in the previous six years. Only doctors with no outstanding fitness to practise investigations or sanctions were granted temporary registration (General Medical Council, 2020b, 2020c).

While temporary registration was automatic, doctors could choose to opt out; they were also not required to work even if they were granted temporary registration (General Medical Council, 2020c). Temporary registration only enabled doctors to work (until 30 September 2022) on pandemic-related activities such as treating coronavirus patients, covering for colleagues who were treating coronavirus patients, or working on the vaccination programme; they were not permitted to work in private practice or in formal training posts (General Medical Council, 2022h). Although fully registered, therefore, these registrants had conditions imposed on their ability to practise medicine, with a situation of 'crisis' enabling the regulator to create a different type of registration. As was the case with the other illustrations that we have discussed in the paper so far, such 'in-between' registrations are now commonplace in the United Kingdom, despite the perception of a single, shared Medical Register.

In this case, apart from the limitations on the kind of work that doctors on the temporary emergency register could perform, the GMC also created a separate regime for removal, explicitly excluding the temporarily registered from regular fitness to practise procedures, which are set out in the General Medical Council (Fitness to Practise) Rules, 2004. The ordinary procedure for fitness to practise investigations is fairly lengthy, involving several steps. Once a concern is reported, the Registrar first determines whether it is to be considered further; if so, the doctor in question is provided the opportunity to respond to the allegation (Rules 4 and 7). After the relevant evidence is collected, it is considered by two case examiners (one of whom is a medical officer), who can decide to issue a warning or require the doctor to comply with necessary undertakings related to their practice or refer the allegation to the Medical Practitioners Tribunal Service (MPTS) (Rules 8, 10, and 11). If the allegation is referred to the MPTS, doctors have the opportunity to attend a hearing, submit evidence, and call and cross-examine witnesses (Rule 15). The removal of a doctor's name from the Register, the most severe of a panoply of sanctions (including conditions and suspensions) can only be done after a hearing before the MPTS.

These fitness to practise procedures, however, do not apply if temporary registration is extended during an emergency (Section 18A(7), Medical Act 1983). In such situations, the Registrar is authorised to remove a person from the temporary register 'for any other reason at any time, including where the Registrar has grounds for suspecting that the person's fitness to practise may be impaired' (Section 18A(5)(a), Medical Act

1983). This low threshold stands in sharp contrast with the approach to standard of proof of balance of probabilities and procedures usually taken with registered practitioners. The distinction between full and temporary registration is especially stark when bearing in mind that until 2008 the burden of proof for allegations of serious professional misconduct before the GMC had to meet the beyond reasonable doubt threshold of criminal law.

Keeping these statutory provisions in mind, the GMC issued special guidance for removal from the temporary register during the pandemic. Unlike what happens under nonemergency circumstances, the GMC decided that if a complaint against a doctor on the temporary emergency register met either the provisional enquiry or the fitness to practise threshold, an Assistant Registrar 'will ordinarily inform the doctor that their registration has been revoked' (General Medical Council, 2020d: para 16). As per the GMC's thresholds guidance, provisional enquiries would involve

> … cases where, although the allegation initially appears to be serious, we need more information to decide whether to investigate further. This may be because it isn't clear whether there will be sufficient evidence to support the allegation, or because it isn't clear if the allegation is serious enough to raise a question about the doctor's fitness to practise and obtaining further information such as expert medical advice might clarify that the allegation is not as serious as it first appeared (General Medical Council, 2021b: para 13).

As per the policy issued at the start of the pandemic, a decision to remove temporary registration was to have 'immediate effect' (General Medical Council, 2020d: para 19). There was also no right to appeal or review the Registrar's decision to remove temporary registration (General Medical Council, 2020d: para 23). The GMC also decided that they 'will not publish our decisions publicly' although the online register would be updated 'to reflect that the doctor no longer holds registration or a licence to practise' (General Medical Council, 2020d: para 22). As per the policy, '[a]ny doctor who is granted temporary registration will have this clearly identified on their public record on our LRMP. LRMP will not indicate that a doctor's temporary registration was revoked but it will display the dates that TR was held' (General Medical Council, 2020d: footnote to para 22).

Despite the severity of the sanction – erasure from the Register – and the fact that the threshold for provisional enquiries is relatively low – involving cases in which the evidence may be insufficient – the GMC's pandemic policy included none of the regular procedural protections for doctors on the temporary register. These changes were justified by the existence of an emergency. The GMC's policy specifically stated that the 'overarching objective' during an emergency 'remains the protection of the public'. Owing to the broad nature of the GMC's powers in such a situation, they were 'not required to ask for any further evidence to support a concern about a doctor; to carry out an investigation; or to provide the doctor with an opportunity to respond to the concern' although such processes could be activated if necessary. Although the policy acknowledged that any concerns during the emergency were 'likely to have occurred in exceptionally challenging circumstances', the GMC also insisted that 'this context will be taken into account', suggesting that the use of the 'existing triage system to establish if the concern is serious enough to suggest that the doctor may not be fit to practise during the emergency is a

robust and proportionate approach in the circumstances of an emergency' (General Medical Council, 2020d: para 15).

The absence of published decisions on removal of names from the temporary register makes it difficult to analyse the effects of the GMC's pandemic policy. However, the lack of procedural protections for those on the temporary register could have particularly onerous effects on BAME doctors, given the existing research on how they are more likely to be referred to the GMC by their employers (Atewologun and Kline, 2019: 3; Health Education England and NHS Improvement, 2019: 6–7). What is clear is that a public health crisis was invoked to make yet further changes to the Medical Register, with the effect of eroding safeguards of recognition and protection initially afforded by the creation of the list of registered professionals.

Conclusions

This paper demonstrates how four crises embedded themselves in the texture of the Medical Register: the need to respond to staff shortages during the First and Second World Wars by relying on medical graduates from British colonies and other countries; the felt need for the United Kingdom to negotiate the relationship between the British Empire and the market and political imperatives of the European Economic Community; the labour market pressures for a quick expansion of a competent medical workforce; and the emergency provoked by fears of a staff crisis at the start of the 2020 global pandemic. In each of these cases registration served as a useful instrument to resolve perceived discrete contingent puzzles in relatively simple, bureaucratic, and formatted ways. From these four illustrations, we can begin to chart some conclusions about everyday and exceptional modalities of the medical registers, and propose new questions for sociolegal histories of registration.

In the four cases, registers served as short-term solutions to situations that were perceived as crises. Our final example, the temporary emergency register created during the coronavirus pandemic is the most striking example of a crisis moment that generated emergency thinking and practices. This register, with its exceptional removal procedures, truly fits the figure of the emergency mode, short circuiting regular processes in favour of efficient, reactive measures. Veiled under calls for immediate action and 'extreme concerns' voiced by GMC and other policy architects of transformations to the register, of course, is the question of what exactly was in crisis. In turn, we can ask more broadly what these crises were made of, and whether they were transformative?

For Roitman (2020), crisis is a *claim*: it detects and qualifies a situation in the world and in turn, generates specific concrete effects. From then, the claim makes certain things visible and at the foreground, whilst others recede in the background, such as discussions about what exactly is in crisis, how and according to whom. In this sense, crises are constitutive, as Mbembe and Roitman (1995) note, and therefore different types of crises create different subjectivities and fields. A crisis claim normatively calls for interventions: it precipitates fast-paced decisive action, such as evaluation, assessment and critique, and then, sometimes, transformation and reorganisation. However, Roitman and others (2020) point out that the pathway of crisis is always highly political but not

necessarily leading to meaningful change. Crises might engender transformations, but often they do not, and instead serve to reinforce the status quo and racial and gendered hierarchies. Fast-paced measures, for example changes to the Register, fixed temporary problems in discrete ways but did not really and systematically transform the UK organisational agendas over health, labour, and preparedness. This often all happens packaged in the language of necessity and inevitability, which according to Mbembe and Roitman (1995: 325) creates a space for action that is simultaneously constrained and feels reasonable, rational, and legitimate.

We nevertheless identify one major systemic transformation generated by these crises of the Register. Over time, its symbol and guarantee of protection for registrants has been eroded in differentiated ways. Initially created precisely to recognise and protect competent health practitioners, the Register did originally provide better safety, status, and income to all registrants. Registration in this sense was even compared to a 'passport' (Stacey, 1989: 19) to authority, legally protected entitlements, and higher rate of payment. Haynes (2017) and others have shown abundantly how these benefits of registration were modulated based on race, gender, nationality, class, and geographical regions. Our paper has documented how various crises have fragmented and weakened the Register itself (by creating different categories of medical workers who are afforded different levels of professional recognition and protection) but also the powerful cultural significance attributed to it.

The Register remains a significant way for professionals to claim membership, but other professional and elite affiliations provide safe belonging in the form of lists of names, for example, lists of graduates of a particular medical school, specialist associations, or membership of a club or fraternity. These essentially social lists are often more informal and exclusive, and have many of registration's dividends, some of which surpass those of registration. Stacey notes that despite full registration on the 'principal list', overseas doctors sometimes lack membership to these additional lists guaranteeing networks of people willing to cover for them (Stacey, 1992: 149) or provide testimonials during disciplinary proceedings.

The erosion of the protection afforded by the fragmentation of registration is not an anomaly, and in fact mirrors the fragmentation of the professions observed by commentators (Abel, 1986; Francis, 2011). In fact, the breakability of registration's protection and safeguards over the years shows that professionals are being made more precarious not despite their registration, but partially because of it. Each of the registers that we have described in this paper ultimately placed barriers on the ability of the registrants to work. Colonial and Foreign Lists permitted overseas medical graduates to get onto the Register but limited their capacity to work in British colonies on an equal footing with their British counterparts. The temporary register that was initially created to meet the workforce demands of the Second World War, and later the NHS, forced European medical graduates to return to their home countries after five years. Roles such as SAS and LE doctors were supposed to offer flexibility for medical professionals but have also ended up limiting the career progression of largely BAME and international medical graduates. The temporary register of the coronavirus pandemic drafted thousands of doctors to assist during a health emergency but stripped them of almost all the procedural protections offered to medical professionals. Being flexible and multiple, and no

longer a rigid single list, the Register is influenced by, sustains, and makes bureaucratically feasible significant managerial and political choices.

The idea is not to exceptionalise the medical register from other registers. Because of space constraints in this article, we had to leave out registration and its connection with self-regulation in other health professions including nursing and midwifery (e.g. Davies and Beach, 2000). Yet it is clear that this particular list, the Medical Register, modulates the supposedly 'bounded' fixed and reliable list within the history of documentation, and offers a contemporary illustration of registration as a technique of governance. The paper has not addressed the ramifications of the transformed Register for different registrants and regulators, but we hope it has added complexity to the contexts of the register and shown that the historical and contemporary human experiences of professional registration need further examination.[1] Lists, such as registers, have vast potential to engender critical and impactful questions of their own (Muller-Wille and Charmantier, 2012). This special issue shows that this potential is increasingly on the radar of legal and sociolegal scholars.

Data Access Statement

All data underlying the results are available as part of the article and no additional source data are required.

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Note

1. The AHRC funded research project *Making it to the Registers: documenting migrant carers' experiences of registration and fitness to practise* aims to examine these and other questions related to overseas-trained doctors and nurses who move to the UK, see: www.makingregisters.leeds.ac.uk

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