
Revalidating Doctors Ensuring standards, securing the future: Response to the General Medical Council consultation document

Introduction

The Academy supports the principles of revalidation and welcomes the opportunity to comment on this document. We are, however, concerned that the current proposals may pose particular problems for clinical academic staff at a time when existing career disadvantages are increasingly recognised. Indeed the considerable expansion of medical undergraduate numbers in England will require the recruitment of more clinical academics who will undoubtedly wish to ensure that revalidation does not inhibit their ability to deliver all aspects of their post - high quality teaching and research as well as patient care. Any continuing uncertainty will make the necessary recruitment more difficult.

Answers to the Specific Questions

Question 1: We would welcome further comment on the principles of revalidation. We want to be sure they are acceptable, comprehensive and sound.

1. The principles and attributes of revalidation are acceptable.

Question 2: Comments on the suggested contents, and on the extent and kinds of information which might be included in the folder, would be welcome.

2. The suggested contents of the folder are reasonable but incomplete. How does the outcome of the appraisal process link with revalidation? Paragraph 34 refers to guidelines to be produced by the Medical Royal Colleges and Specialty Associations without discussing the contractual issues being negotiated between the Government and the BMA. Realistically, the contents of the folder and the extent to which the outcome of the appraisal process can be included will inevitably be influenced by these negotiations. The current proposals are, in our opinion, not realistic.

Question 3: We welcome comments on whether the doctor's folder should contain evidence only of complaints that have been upheld or should include all complaints that are sufficiently serious to raise a question about the doctor's registration, whether upheld or no. We would also like your views on whether anonymous complaints can be excluded.

3. We are surprised at the possibility that revalidation might be withheld because of complaints that have not been substantiated. It seems to us entirely

unacceptable that a doctor's fitness to practise should be questioned on the basis of such allegations, anonymous or not.

Question 4: In our view it is possible to meet the legitimate public interest that evidence of dangerous practice is dealt with promptly and effectively without damaging the effectiveness of appraisal. The way to do this is to be absolutely clear about the purposes and mechanisms of appraisal. Box 8 sets out our suggestions, on which we would welcome comments.

4. Box 8 appears to contain your views of the appraisal process currently the subject of contractual negotiations between BMA and Government. We note your opinions but at present are unaware that they will be reflected in the appraisal process to be implemented in England; the arrangements for Scotland, Northern Ireland and Wales are even less clear to us at present. In answer to Question 8, we question the ability of the GMC to modify the contractual basis of appraisal that is eventually approved by Government and believe that revalidation will inevitably reflect and not lead that process. The current proposals from the GMC on the links between appraisal and revalidation seem to us unrealistic.

Question 5: Deciding how frequently doctors should be revalidated requires balancing the need to avoid a burden that might interfere with the doctor's ability to deliver care, against ensuring that there is a credible process to protect patients. A period of five years would seem to strike an appropriate balance. We would welcome your views.

5. We agree that a period of five years for revalidation is reasonable.

Question 6: The revalidation group could record the required actions on the revalidation certificate, to enable us to check that the action is being pursued. Comments on this proposal would be welcome.

6. While it is reasonable that required actions should be recorded on the revalidation certificate, this proposal again raises questions on the link between appraisal and revalidation. Is it suggested that such records, formulated every five years, might differ from the outcomes of the annual appraisal process?

Question 7: We would welcome views on what would be appropriate lay involvement. For example, should the lay members be recruited from the public generally or should they have some health sector related experience?

7. The practicalities of recruiting lay members of the revalidating panels from the general public are considerable. We believe that the lay members should have some health sector related experience - easing the process of identification.

Question 8: It has been argued that where doctors work within a managed organisation, the revalidation group member who has knowledge of the doctor's practice (see paragraph 57a), should be a representative of that organisation. We would welcome your views.

8. We agree.

Question 9: One possibility is that locums make use of the lists that we might maintain of accredited individuals who could conduct the end of the cycle assessment for doctors working outside managed organisation. Alternatively, where possible, locums could make use of the institutional arrangements at their current place of employment. A third option is for locums to be covered by any new systems of appraisal introduced by the NHS. A fourth option, being developed by the National Association of Non Principals in General Practice, is to create for their members a 'virtual practice' to assist the process. These and other ideas need further discussion. We would welcome your views.

9. We believe that wherever possible the arrangements for locums should be those followed at their current place of employment - and compatible with NHS appraisal procedures. As the onus for revalidation remains on the individual doctor, the GMC should, as far as possible, avoid creating special arrangements for locums.

Question 10: Under our proposals, they (*doctors*) would have a choice: they could choose to transfer to the non-revalidating list or part of the register (see paragraph 92), or they could choose to retain the full privileges by participating in the revalidation process, producing evidence of their continuing fitness to practise. We would your views on these proposals.

10. We have no information on the numbers or job descriptions of those doctors who, according to the Consultation Document, "may not need to exercise those privileges (of registration) in order to perform their jobs". If indeed such doctors exist, we do not oppose this proposal.

Question 11: However, if a retired doctor did wish to be revalidated then they would have to submit an objective assessment of their fitness to practise along the lines described in paragraph 45 above. We would welcome your views on this.

11. We agree with this suggestion.

Question 12: We would welcome your views on our proposals in respect of doctors who are working abroad.

12. We agree that the arrangements for doctors returning to practice in the UK should be the same as doctors returning after a career break. We are, however, concerned that these arrangements are ill-defined and are likely to act as a significant deterrent to the increasing numbers of doctors who wish to return to clinical practice.

Question 13: Doctors who have decided not to participate in revalidation could, if they wished, have their names placed on a supplementary list of doctors who were qualified to practise. Alternatively, the register could contain two categories of doctor: those who are in the revalidation process and those who are not. Either solution would enable members of the public, employers and fellow doctors to check the status of doctors. Your comments on these options would be welcome.

13. Although we do not oppose this proposal, we would wish more information on those doctors who are likely not to participate in revalidation. On balance we

favour the creation of a supplementary list of those who were qualified to practise.

Question 14: Doctors who have demonstrated their fitness to practise will retain all the legal privileges and obligations of registration. The issue is what – if any – privileges and obligations those who are not participating in revalidation should retain. We would welcome views about which – if any – of the privileges of registration it would be safe to allow un-revalidated doctors to retain. We will then seek legislation to enforce this. We will consult further on this.

14. We are not in a position to comment on this question. Given the number of references to "registered medical practitioner" in UK statutes this is a complex issue with potential ramifications well beyond immediate patient care. We believe that more information is required before a rational decision can be made.

Question 15: We would welcome your views on the length of time that a doctor might be out of practice before the requirement to return under supervision might apply.

15. We believe that this question requires considerably more thought. There are no specific suggestions about the supervision that may be required on returning to practice only a series of bland statements. We believe that the important aspects relate to competence and/ or performance and not to time. How should competence be assessed? Is it more appropriate to determine performance in practice? Should there be a period of "probation" - and, if so, how does this relate to the appraisal process being adopted by the NHS the major employer? Creating unnecessary barriers to deter good doctors from returning to practice may not be the best way forward at a time when the shortage of doctors is increasingly acknowledged. We believe that more details of the GMC proposals are essential before a considered decision can be made.

Question 16: Inevitably some doctors being considered under the fitness to practise procedures will be due for revalidation. If the doctor's revalidation date were publicly recorded on the register, it would be clear that the doctor, while registered, was overdue for revalidation. One view is that this could undermine the presumption of innocence. The alternative view is that the public is entitled to know. We welcome views on this subject.

16. The answer to this question depends upon the delay in reaching a decision on the fitness to practise issues. If the process is efficient, the revalidation decision should be deferred until the outcome of the investigation is known. It would not seem logical to decide upon revalidation while a fitness to practise investigation is in process. As the proposals originate from the GMC, that organisation must accept responsibility for providing an efficient service both for patients and for doctors.

Question 17: We conclude that a doctor should be under a duty to include this information in their folder and that we should disclose on request to the revalidation group information on past decisions. That would provide the local revalidation group with a means of checking that the doctor had fulfilled the disclosure obligations. We welcome views on whether there should be a time limit after which past findings would not have to be disclosed.

17. We accept that past decisions should be revealed.

Question 18: We would welcome your views on whether any such committee (*a new CMC Committee*) should have the discretion to award costs for or against the doctor.

18. Yes

In seeking to answer the questions posed in the Consultation Document, we are aware that a number of other issues have not yet been explicitly addressed. The arrangements for the External Quality Assurance remain obscure, as are the requirements for sampling. If an annual appraisal process is to be introduced for the NHS in England, what is the role of revalidation every five years? The likelihood remains that the outcome will be bureaucratic without providing any real reassurance to the public and the profession that poorly functioning doctors will be detected early.

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