Revalidation for what?

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Having reached my sixties I am thinking about retirement but hope to keep up an interest in medico-legal practice and perhaps some epidemiological research. As I read the consultation document *Revalidating Doctors – Ensuring standards, securing the future* from the General Medical Council I was concerned about its implications for me after I retired from active clinical practice. This led me to think that there were many doctors whose careers did not involve direct clinical work. Did they need to be revalidated? So I was relieved when Charles introduced the subject over dinner.

'A friend of mine is a lay member of the GMC, and she showed me the document *Revalidating Doctors*. 'What do you think of this?' she said 'Don't you think it's a very good start?' I glanced at it, and she was taken aback when I replied 'You are suggesting retrospective legislation – a very dangerous practice'.

'I have just read it myself, Charles.' I interjected. 'The retrospective nature did not occur to me, but I was worried about the implications for me if I continued to do non-clinical work after retirement. This made me reflect that there are many doctors in the middle of their careers who are doing non-clinical work but nevertheless are required for legal reasons to be registered medical practitioners.'

'The two points are not unconnected.' he said. 'The retrospective element is particularly hard on those with non-clinical careers, particularly if those who do not revalidate lose their registration. My feeling, and I'm sure it is yours as well, is that the GMC has not thought sufficiently about the question "Revalidation for what?" and the implications of the retrospective nature of their proposals.'

'How would you solve the problem?' I asked.

'Retrospective legislation can only be justified in extreme circumstances. It could be argued that increasing loss of confidence in the medical profession is sufficient to justify retrospective legislation, but this argument could only be sustained in the context of clinical practice. Furthermore, the cardinal principle of retrospective legislation should be that, in so far as is possible, there should be no detriment.'

'Yes, I think that is important: after all, when I first registered it was for life for one fee. First an increase in registration fee was demanded, and now it looks as though I am going to be put to the expense and trouble of demonstrating continued competence in clinical practice from which I anticipate retiring in the near future. Furthermore, my practice has become increasingly specialised over the last few years, and I am sure that this trend will continue with my colleagues for the foreseeable future. Are they expected to show competence in all aspects of medicine, or only in what they are doing? It would be unrealistic to accept the former.'

'Agreed, Coe,' he said, 'but that means that any list of revalidated medical practitioners would be useless unless it stated categorically for what they had been revalidated. If the patient wants reassurance that a doctor treating his heart is competent, a revalidation list is useless if it was based on demonstration of ongoing skill in gastro-enterology, let alone orthopaedic surgery. Indeed, you tell me that now in one speciality, consultants are becoming more specialised, for example, concentrating on asthma rather than lung cancer.'

'So you suggest that published lists should be very specific in stating in what aspects of medicine a doctor has been revalidated?'

'Yes,' he said, 'and then employers could be very precise in specifying what demonstration of competence they required from the doctors whom they employ, and general practitioners could be confident when they asked for further opinions.'

'But that means most doctors, whether in specialist or general practice, would not be revalidated for most tasks, yet the GMC is proposing a list of doctors who do not revalidate.'

'That is exactly the point that I was making when I told my friend that the proposals are effectively retrospective legislation. Publishing such a list of doctors whose general or specialist registration precedes the proposals, breaches the principle of no detriment. It is both misleading and unnecessary. If it is made clear for which tasks doctors require validation, then only a revalidated list is required and justified, though there may be some argument in favour of a retired list.'

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'That sounds fine for the present, Charles,' I replied, 'but what about the future? I am sure that the pressure for more 'transparency' will only increase.'

'I am sure you are right, but the GMC should start with clinical competence, while accepting from the outset that it will take a few years to be sure that a satisfactory system has been developed. Thereafter they could gradually increase the range of tasks for which some form of revalidation is necessary. At the same time the government should look at legislation, and see which statutes might more realistically require "a person with a degree in medicine" or "a person eligible to be registered as a general medical practitioner". Only then could they be justified in recommending the removal of all privileges of being a registered medical practitioner from those who do not revalidate. Above all, the principle of no detriment is breached by the unnecessary publication of a list of unrevalidated doctors or in withdrawing from them existing privileges not directly relevant to the current process of revalidation.'

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