

**Accessible, Transparent, Informative: Proposals for Registering
Information About Specialist Medical Practice**

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Executive Summary

The GMC's register of medical practitioners is a unique resource. It provides the only up-to-date, publicly accessible database of all doctors eligible to practise in all four countries of the UK. We have committed ourselves to enhancing that resource by improving the accessibility of the register, making a wider range of information available, and making that information more meaningful for those consulting the registers. Many changes have already been made and others are planned. In this report we set out proposals to enhance the information contained in the register about doctors in specialist medical practice.

The GMC's specialist register was established in 1996. Since then, much has changed. In many fields, medical practice is becoming increasingly specialised and the arrangements for specialist training have been re-organised. There have been calls for the registers to carry more information and for that information to be more up to date and relevant to stakeholder needs. We have raised the question of whether the way in which we capture information about specialist practice is currently meeting those needs.

In this report we have sought to build on, rather than discard, the existing arrangements for recording information about doctors' specialist practice, and propose a new, three part model for the registers.

The GMC's plans for re-licensing and revalidation will require it to capture information from all doctors about their scope of practice. That information should be recorded on the face of the register. This will help to make the registers more meaningful and address the gap that sometimes exists between the specialties for which doctors are included in the register and the field of practice within which they are currently working.

The second element of the model would be the specialist register. At present, once doctors have been included in the specialist register they will remain on that register unless they are removed from the register of medical practitioners. Our model proposes that retention in the specialist register should be contingent upon doctors demonstrating that they are continuing to practise to the appropriate specialty standards. We also propose that there should be greater clarity in the way that the information in the register is presented so that its meaning is better understood by those consulting the register.

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The third part of the model draws on the work being undertaken by a number of bodies in the area of specialist credentialing. A specialist credential is a body of knowledge and skills acquired and maintained across a defined area of medical practice within a recognised specialist field. Recording doctors' specialist credentials in the register would help to make it more up to date and transparent because it would be possible to capture the details of specialist competences acquired and maintained throughout doctors' careers, not only at the point they become eligible for inclusion in the specialist register. The development of specialist credentialing is, however, a new idea. Further work will be needed across a number of organisations before credentials could become part of the register.

The Government's 2007 White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, described a new and wide ranging regulatory agenda. Moving forward, it will be essential to frame our proposals in the context of that wider agenda. We are, however, confident that they are wholly compatible with the conclusions of the White Paper.

SECTION 1: Background

1. In December 2005 the Council of the GMC agreed that there should be a review of the fitness for purpose of the specialist register. The review would proceed on the basis that the registers, including the specialist register and GP register, should in future carry a wider range of information than is currently offered, if that could be shown to benefit patients, the public and employers of doctors'.
2. The review would be the second phase of a broader review of our registration structures that began in 2002. The recommendations from the first phase included the abolition of limited registration, the introduction of a new fitness to practise requirement at the point of registration, and a requirement for new registrants to work initially within GMC approved practice settings. Legislation to introduce these and other measures received parliamentary approval in July 2006. Implementation of most of the changes will take place during 2007.
3. The first phase of the review had initially intended to address questions about the fitness for purpose of the specialist register. However, a number of factors caused us to pause. Among them, a series of public inquiries looking at the effectiveness of medical regulation, the publication of the Government's proposals for the reform of senior house officer training (*Unfinished Business*¹) and the imminent creation of the Postgraduate Medical Education and Training Board (PMETB) as the new body responsible for specialist training, were all likely to affect the future regulatory environment. Coupled with this, our own developing work on licensing and revalidation, also made it prudent to defer our plans.
4. But other pressures meant that we could not afford to pause too long. In April 2004, the Government published *Modernising Medical Careers: the next steps*,² setting out the future shape of specialist training. In December 2004 the report of an All Party Parliamentary Panel of Enquiry into the Safety of Laser Eye Surgery in the UK brought forward proposals for the tighter regulation of laser eye surgery, including the establishment of a separate register for laser eye surgeons to be held by the Royal College of Ophthalmologists. In January 2005 the Department of Health Report of the *Expert Group on the Regulation of Cosmetic Surgery*³ highlighted the need for information about specialist qualifications and specialist registration to be made more clearly available to the public. On 30 September 2005 PMETB formally assumed its responsibilities for specialist training.

¹ Donaldson L. *Unfinished Business: Proposals for reform of the Senior House Officer Grade: A paper for consultation*, Department of Health, 2002

² *Modernising Medical Careers: the next steps*, Department of Health, 2004

³ *Expert Group on the Regulation of Cosmetic Surgery: Report to the Chief Medical Officer*, Department of Health, 2005

5. The other crucial development in 2005 was the Chief Medical Officer (CMO) for England's review of clinical performance and medical regulation. In April 2005, in response to the CMO's *Call for Ideas* to support his review, we had signalled our intention to make registration more meaningful.⁴ The CMO's conclusions, set out in *Good doctors, safer patients*,⁵ were published in July 2006, during the course of our review. His report contained recommendations that were directly relevant to the specialist and GP registers. These were considered as part of our review and are discussed within this report.

6. Since the completion of our review, the Government has published its White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, which sets out its response to the CMO's recommendations and those of the parallel review *The regulation of the non-medical healthcare professions*. Any decisions about taking forward the conclusions of our review of specialist registration will now need to be considered in the context of the wider regulatory agenda set out in the White Paper. That wider agenda is not discussed in this report.

SECTION 2: Objectives and remit of the review

Our approach to the task

7. The terms of reference for the review are reproduced at Annex A. The overall objective was to determine whether or not the specialist register meets the needs of stakeholders, and in what ways it could be made more responsive to their needs.

8. The objective of making specialist registration 'more responsive' starts from the premise that it is currently not responsive enough.

9. We recognised at the outset that the specialist register itself is a narrowly defined, legislative tool, the operation of which was, to a large extent, designed to meet the requirements of EC law. Focusing on this alone would necessarily limit the scope of any recommendations for change we might wish to make. We therefore decided that we must be prepared to look more broadly at the opportunities for registering specialist information if we were to fulfil the spirit of our remit by making the registers 'more responsive to the needs of stakeholders'.

10. Similarly, we were keen that our recommendations should try, insofar as possible, to anticipate the future needs of stakeholders. As the introduction to this report makes clear, the environment in which medical regulation operates is a dynamic one. We have tried, therefore, to look beyond the limitations imposed by current structures and practice, and find a model that allows for flexibility and future change.

⁴ Developing Medical Regulation: a vision for the future, GMC April 2005

⁵ Chief Medical Officer for England, *Good doctors, safer patients*, Department of Health, 2006

11. Although our terms of reference focus on the specialist register, the review was launched in the context of the Council decision that all our registers (including the GP register) should in future carry a wider range of information. We were also specifically asked to consider the implications of our recommendations for the 'form and content of the GMC's registers' generally. Accordingly, we have endeavoured to ensure the applicability of our proposals to the future registration of GP, as well as specialist, information.

Some guiding principles

12. To support the terms of reference and aid our developing thinking we established some underlying principles for the review. These would form the key requirements against which we could test the fitness for purpose of the current system and any new proposals that we wished to bring forward. The principles (which include the principles of good regulation originally set out by the Better Regulation Task Force) are reproduced at Annex B.

SECTION 3: Working methods

13. A working group was commissioned to undertake the review. The group comprised medical and lay members of the GMC, as well as representatives from the Department of Health of England, PMETB, the Academy of Medical Royal Colleges (AMRC), NHS Employers, the Independent Healthcare Advisory Service (IHAS) and the GMC's Patient and Public Reference Group (PPRG). The full membership is shown at Annex C.

14. Although the group comprised a number of stakeholder organisations, its thinking needed to be informed by a wider range of views. This was helped by a preparatory seminar held in October 2005 that brought together participants from professional, employer, consumer and patient organisations.

15. Subsequently, the group took evidence from Dr Mike Watson, Medical Director NHS Scotland and Chairman of the AMRC CPD Sub-Committee, and from Professor John Lowry of the Cosmetic Surgery Interspecialty Committee of the Senate of Surgery of Great Britain and Northern Ireland.

16. The group was also able to test its emerging thinking through presentations and discussions with a number of different organisations and groups. These included the GMC's Independent Sector Working Group, and PPRG, IHAS, AMRC, the Royal College of Ophthalmologists' Education Committee and the AMRC Patient/Lay Seminar.

17. The group's views were also informed by the results of a survey of over 1,000 doctors on the specialist register, which looked at the relationship between their entries in the register and their field of actual practice.

18. Finally, research was commissioned from SHM Ltd to help the group understand the needs of those who currently use, or might in future use, the

GMC registers to obtain information about specialists. The researchers adopted a number of different strategies, beginning with literature reviews and comparisons with other registers in the UK and overseas, both within healthcare and in other sectors. This work was followed by a series of questionnaires, interviews and workshops with key groups of stakeholders. These covered questions about the registers in their current form and the ways they might be extended in the future. Further details of the research are given in section 5 of this report.

19. The working group met on four occasions during the course of 2006. The recommendations in this report represent the group's conclusions. It is hoped that they will provide the basis for full public consultation on the way ahead.

SECTION 4: The specialist register and current legislation.

20. The first part of our remit was to clarify the purposes that the specialist register must fulfil according to current legislation. To understand the purpose, it is first necessary to say something of the origins of the specialist register. The following paragraphs provide a short history.⁶

The requirements of EC law

21. The purpose of EC Directive 93/16/EEC (the 'Medical Directive') is to facilitate the free movement of doctors throughout the EEA. The Directive sets out the minimum requirements for basic and specialist medical training in Europe. It also provides the basis upon which European doctors holding the appropriate qualifications are entitled to have their basic and specialist qualifications recognised as they move between EU member states. Each state is required by the Directive to 'recognise the diplomas, certificates and other evidence of formal qualifications in specialised medicine awarded to nationals of Member States by the other Member States...by giving such qualifications the same effect in its territory as those which the Member State itself awards' (93/16/EEC, Article 4).⁷

22. Prior to the introduction of the specialist register in 1996 there was no title of specialist in the UK. The only two criteria that reflected the attainment of specialist status were appointment as a consultant in the NHS and 'accreditation' by a medical Royal College. However, it was not usually possible to be accredited on the basis of EEA qualifications or experience because the training required by the Colleges was almost always longer than the minimum required by the Medical Directive.

⁶ Hospital Doctors: Training for the Future – Proposals for Implementing Legislation: The Specialist Medical Order, Department of Health, 1995.

⁷ In September 2005 the Medical Directive by Directive 2005/36/EC on the recognition of professional qualifications (the 'Qualifications Directive'). The Qualifications Directive must be implemented in UK law by October 2007.

23. The fact that EEA doctors with specialist qualifications listed in the Directive did not have the right to accreditation or to be regarded as sufficiently trained for the purpose of being appointed as a consultant was seen by the European Commission as offensive to the principle of free movement of doctors within Europe.

24. Faced with the prospect of infraction proceedings by the European Commission, the UK government proposed a new system, which included the creation of a Certificate of Completion of Specialist Training (CCST) for UK, trained specialists.

25. Doctors holding a CCST would be eligible for inclusion in a new specialist register. This specialist register would also include those holders of EEA specialist qualifications listed in the Directive who wished to practise in the UK. A person wishing to be eligible to take up an appointment as a consultant in the NHS would have to be included in the specialist register. EC law does not require us to hold a specialist register, and not all European regulators have one.

The requirements of UK law

26. The specialist register was established in 1996 under the European Specialist Medical Qualifications Order 1995 (the '1995 Order'). The 1995 Order was replaced in 2005 by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (the '2003 Order').

27. The 2003 Order makes the PMETB responsible for specialist and GP education and training in the UK leading to the award of a CCT and eligibility for inclusion in the specialist and GP registers. The GMC is responsible for holding and maintaining those registers (Articles 10 and 13).

Keeping the specialist register (Article 13)

28. The specialist register must include the specialty in respect of which each person's name is included in the register, and the name of any field of practice within that specialty for which a doctor has satisfied the PMETB that he has particular expertise and has completed the appropriate sub-specialty training. It does not include any information about doctors' training or qualifications beyond the point at which they obtain their CCT⁸ and become eligible for inclusion in the specialist register. We consider this further in Section 5 of our report and in Section 8 in relation to specialist credentialing.

⁸ Under the provisions of the PMETB Order, the Certificate of Completion of Training (CCT) has replaced the CCST.

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Access to the specialist register (Article 17)

29. The GMC is required to publish the specialist register 'electronically or otherwise'. However, the specialist register is not published as a separate document. Instead, the GMC meets its obligations by including details of a doctor's specialist status within the integrated database of registration information contained in the on-line list of registered medical practitioners (LRMP). A person consulting the LRMP is able to see, within a single register entry, both the basic registration information of a doctor and any specialist registration details that may apply for that individual. An example of a register entry is at Annex D.

Requirements for inclusion in the specialist register (Articles 3-15)

30. To be eligible for inclusion in the specialist register a person must be a registered medical practitioner. He or she must also hold either a CCT in a UK specialty, or a recognised EEA specialist qualification, or fall within a group of other eligible specialists defined in Article 14 of the PMETB Order.

Inclusion in the specialist register is voluntary, so doctors must apply if they wish to be included.

31. Under the provisions of the Order, a doctor wishing to be eligible for appointment as a consultant in the NHS must be on the specialist register. However, there is no such statutory requirement for doctors taking up locum consultant positions. There are also a number of consultants who were in post before the specialist register was introduced who have not applied for inclusion in the specialist register. The working group noted that such factors did not help the transparency of the register and were a potential cause of confusion. However, we considered that these were fundamentally matters for employers to address and outside the remit of the present review.

Removal from the specialist register (Article 18)

32. The Order contains provisions for the removal of a doctor's name from the specialist register. These include cases where a doctor ceases to be a registered medical practitioner and where an entry has been fraudulently procured or incorrectly made. There is no other facility for removing a doctor's name from the specialist register.

33. We noted that there is currently no provision for action against a doctor's entry in the specialist register in cases where a doctor's fitness to practise is found to be impaired in relation to his or her specialty. This is relevant to the recommendations on specialist accreditation contained in the CMO's report, *Good doctors, safer patients*, which we discuss in Sections 9 and 12.

The practical effect of the specialist register (Article 13)

34. The specialist register is mainly indicative and permissive in its intended effect, rather than restrictive and prohibitive. It indicates who is eligible for consideration for appointment to certain posts within the NHS. It does not prevent doctors who are registered in respect of a particular specialty from working in other specialties. Nor does it prevent individuals who are not on the specialist register from undertaking particular specialist procedures. We consider this further in Section 10 of our report on privileges and regulatory effects.

SECTION 5: Defining the problems

35. In clarifying the legislative purpose and principal features of specialist registration, we have hinted at some of its shortcomings. We explore these further in the following paragraphs. This will help us address the second part of our remit: to consider whether the specialist register should, in future, fulfil additional or alternative purposes.

What does the specialist register actually tell us?

36. The specialist register is a record of historical achievement. It shows the specialty for which a doctor was originally included in the register, but nothing about the nature of current practice or fitness to practise in that field.

37. In 2005, the GMC surveyed 1,250 doctors on the specialist register. The response rate was 72%. The survey found that 86% of respondents were working exclusively in the specialty in which they appear in the specialist register, or in a sub-specialty of that specialty. 4% were working in a wholly different specialty from their registered specialty. Around 10% were working in their registered specialty and in another specialty. Some 6.5% were no longer in active medical practice.

38. All registered medical practitioners are under a professional obligation to recognise and work within the limits of their competence.⁹ We received no evidence that specialists were working outside their field of competence. The survey findings may simply reflect the fact that after doctors have completed the requirements for entry to the specialist register, their practice continues to develop and their specialist interests move into other areas. The specialty itself may change. We received expressions of concern from one medical Royal College about individuals contracting to undertake sub-specialist work with little or no documented evidence that they had the appropriate training or experience.

39. What the survey suggests is that the specialist register is an unreliable indicator of a doctor's current field of practice and specialist competence. This may not matter. It was not what the specialist register was set up to do. But

⁹ Good Medical Practice, p7

the GMC has committed itself to making the registers more meaningful. As we shall see in section 6, the gap between registration information and actual practice contributes to public misunderstanding of the meaning of the registers.

40. In his report *Good doctors, safer patients*, Sir Liam Donaldson recognises the need to make the specialist and GP registers a more up to date statement of doctors' competence. He proposes to address this by building on the GMC's revalidation model with a system of re-certification for specialists and GPs (see Section 12).

41. In Section 11 we consider a new model for specialist registration that will provide a more up to date account of doctors' training, current practice and continuing competence in their chosen field.

The changing nature of specialist training

42. We heard evidence from within our working group, and from those who presented to us, about the changing nature of specialist training. Increasing specialisation and the implementation of the Government's *Modernising Medical Careers* agenda mean that 'a greater proportion of more advanced training will take place following the acquisition of a CCT'.¹⁰ This is not currently being captured by the specialist register because the register refers only to training leading to the award of a CCT.

43. We also heard from the PMETB and the AMRC about moves towards the modularisation of specialist training. Increasingly, doctors would develop competences in particular areas of specialist practice as they move through their careers, regardless of whether they are in CCT training programmes or career grade posts.

44. It was clear to the group that the nature of specialist training and specialist practice will in future be very different from the model that applied when the specialist register was set up in 1996. In its current form, the register is unable to reflect these changes. We therefore needed a new model that acknowledged the changes that were already taking place, and was sufficiently flexible to accommodate further changes in the future.

Information in the specialist register

45. Although the UK awards CCTs in 56 specialties, there are around 270 specialties currently listed in the register for some 50,000 doctors. One of the main reasons for this is that when the specialist register was introduced, the legislation included transitional provisions entitling registered medical practitioners who were, or had been, a consultant in the NHS in a medical specialty, or who had been accredited in such a specialty, to apply for specialist registration. This has resulted in doctors entering the specialist register in a wide range of different specialties in which they have held

¹⁰ *Modernising Medical Careers: The next steps*, Departments of Health, 2004, p7.

consultant posts, not necessarily confined to the specialties in which the UK awarded CCSTs. Different provisions in the PMETB Order (Article 14(5)) also make it possible for doctors to be included in the specialist register for specialties other than those in which the UK currently awards CCTs.

46. Whatever the reason for the proliferation of specialties in the specialist register, there is currently no meaningful way for a non-expert audience consulting the register to make sense of the information that it contains. This is very much borne out by the research findings of SHM discussed in section 6 of our report. The register therefore fails to satisfy the principles of accessibility and clarity that we have set (Annex B).

SECTION 6: Understanding user needs

47. Our remit required us to consider the benefits for patients, the public, the profession and employers, of providing information through the specialist register, as opposed to through other sources.

48. The seminar held in October 2005, and presentations to key organisations during the course of the review, gave us some understanding of the concerns of different stakeholder groups. In particular, they helped us to clarify the shortcomings of the specialist register and discuss our proposed solutions.

49. Research commissioned from SHM Ltd enabled us to engage more directly with individuals who actually use, or might have reason to use, the register, and understand their needs more clearly. The discussion in this section of our report is based on the findings contained in SHM's written report and the presentation of those findings to our working group in October 2006.¹¹

50. SHM was asked to look at the needs of three groups of stakeholders: employers and contractors, patients and the public, and doctors. These groups included different sub-groups: for example, NHS and independent providers, GPs, specialists and trainees, patients who had consulted a specialist, those who had not.

51. One of the key findings of SHM's work was that the registers are used less as a means of transferring information to users, than as a means of transferring risk away from them. In this process of risk transference, the register is seen as an authoritative document that provides certain guarantees. This has important implications for the review in terms of the type of information the specialist register should contain and the reliability of that information.

¹¹ The Specialist Register: understanding user needs, Final Report by SHM, September 2006.

Employers and contractors

52. For employers and contractors, the primary use of the register is to check the legitimacy of an applicant prior to short-listing. The specialist register was one of many tools that employers use to minimise their risk.

53. Employers were equivocal about the value of expanding the register to provide additional information since this would not necessarily reduce their risk. Indeed, there was some concern that the GMC might decide to include unverified information. This would undermine confidence in the register generally as a provider of guarantees.

54. There were, however, two areas where further information would be welcomed. The first related to limitations on practice. The second concerned information about sub-specialty practice which some employers saw as useful in helping them to establish a doctor's competence.

55. Information about limitations on practice is already available through the LRMP, though there may be a need to consider whether more could be done to make this accessible. That is outside the scope of this review. The issue of sub-specialty practice is something we return to in section 8.

Patients and the public

56. SHM's research suggests that patients and the public rarely seek information about specialists. Their awareness of the GMC and of the registers tended to be superficial. This seems not just to be a function of the UK healthcare system or because of the limited usefulness of the specialist register. Comparisons with the United States indicate that even in a consumer orientated society where regulators provide a considerable amount of consumer information to aid choice, the public rarely ask questions about the qualifications of specialists.

57. SHM's findings indicate that, were the public to consult the register for information about specialists, many would misinterpret the information provided because of the way it is currently presented. SHM researchers showed 65 patients the register entry of a doctor registered for the specialty of cardiology. They were then invited to interpret the significance of the information it contained by responding to a series of statements. Among the responses given, 6 inferred that the listed doctor was one of the UK's leading cardiologists; 19 inferred that the doctor was not allowed to work in specialties other than cardiology; 34 believed the doctor was currently working in cardiology; 19 believed that the doctor would be able to give them the most up to date treatment available in cardiology; 15 believed that the doctor's performance in cardiology had been assessed by the GMC in the last five years; 14 believed that no one had ever made a complaint about the doctor to the GMC. Regardless of whether the registers should provide further information for the benefit of patients and the public, this evidence highlights

the need for greater clarity and transparency in the information that is currently available.

58. The fact that the public rarely seeks information about specialists is in part explained by the fact that, when they do need information, their approach tends to be structured around the problem they are experiencing, rather than the specialist who will treat it. They require a 'my problem register' rather than a register of specialists. Those who said that they might consult the register indicated that their aim in doing so would be to establish a doctor's legitimacy. Beyond the basic guarantees of a practitioner's legitimacy that the medical register brings, the nature of the information patients are likely to seek is precisely that which a specialist register cannot provide. The register cannot tell them which doctor is the right doctor for their particular problem, or to meet their individual needs. These needs are 'almost certainly too personalised and diverse to be gatherable in practice'.

59. It should be added that, like employers, patients did not welcome the inclusion in the register of unverified information, even if that information were to be accompanied by disclaimers. This points strongly away from using the registers to include the sort of consumer information that is characteristic of some of the registers held in other jurisdictions; such as information about doctors' proficiency in languages other than English and whether they are taking new patients.

60. The idea that patients will automatically benefit from a wide range of additional specialist information being available on the registers may therefore be misplaced. Patients clearly have a need for information, but that information must be targeted and relevant. The appropriate role for the GMC may be to help them find appropriate sources of information and advice, rather than attempt to provide all the information itself.

61. This was borne out by some of the feedback we received from a presentation given to the AMRC Patient/Public seminar in September 2006, where it was pointed out that the GMC registers were just one element in a web of information that patients and the public require. The GMC could not and should not try to provide all of that information, but might be well placed to help patients find the additional information they require.

The profession

62. SHM's research showed that doctors had a range of views about the registers. Some saw their registration in purely functional terms; the thing that allows them to work. Others viewed it as both a confirmation of their legitimacy, and an assurance of their professionalism; a guarantee of standards of practice and professional behaviour.

63. Views about the inclusion of additional information varied. Many were concerned that any additional information provided to the public should be accurate and help to guide decision-making, and not create confusion. For

this reason, there was concern about the inclusion, for example, of medical data, performance statistics and mortality rates, which might be misleading and would require interpretation. Some argued that whilst in-depth information of this kind might be helpful, it is better provided by sources other than the GMC. Any information provided by the GMC must be verified.

Adding value

64. SHM's work has pointed strongly towards the registers providing additional information for employers about doctors' sub-specialties. But to avoid undermining the credibility of the registers as a whole, any information must be verified.

65. Patients and the public are not using the register to obtain information about specialists, and it is not apparent that the register itself is the most appropriate mechanism to meet their additional information needs in respect of specialists.

66. The GMC may, however, have a role in helping patients to link with other sources of information, such as organisations and websites providing material about medical conditions, or even to doctors' own websites. The GMC website already provides some links of this kind, pointing patients to organisations such as the Patients Association, the Patient Advice and Liaison Service (PALS), and the Department of Health guidance on cosmetic surgery.

67. We may wish to encourage others to provide links to our registers. A by-product of establishing such linkages would be to increase overall awareness of the registers without the registers themselves providing further information.

68. From a patient perspective, the need is not for the registers to be used for additional or alternative purposes, but to improve the existing product so that its meaning is clear and comprehensible. We referred earlier in this report to the lack of clarity associated with the recording of over 270 different specialties. SHM's work has identified misunderstandings among users about the meaning of the specialist information currently provided. We have also noted potential confusion over the fact that in some cases it is not necessary to be on the specialist register in order to work as a consultant in the NHS. One observation made during the course of the review was that the register was not in fact a specialist register at all, but a register of individuals eligible to take up certain consultant posts.

69. The key message from SHM's work was that although there were some audiences for whom additional specialist information would be useful, we needed to avoid 'compromising the unique product offered by the GMC and its ground in verification'.

SECTION 7: The independent sector and cosmetic surgery

70. One of the drivers for this review has been the report from the Department of Health *Expert Group on the Regulation of Cosmetic Surgery*. It was therefore important for us to consider the implications of that review and its recommendations relevant to the specialist register.

71. Most specialists are registered for their particular specialty in the specialist register. For example, a consultant cardiologist will be registered for the specialty of cardiology. However, this is not the case for cosmetic surgeons. Training in cosmetic surgery in England is limited in availability because surgery in the NHS is carried out for clinical rather than cosmetic reasons. The PMETB does not issue a CCT/CCST in cosmetic surgery and has no plans to do so. Consequently, there is no specialty of cosmetic surgery for which doctors can be included in the specialist register. Doctors carrying out cosmetic procedures will normally be included in the specialist register for another specialty, such as plastic surgery or general surgery.¹²

72. The report of the Expert Group concluded that the present situation is unsatisfactory because it is almost impossible for a person seeking cosmetic surgery to understand or evaluate the precise qualifications and supervisory framework in which their surgeon is practising. The 20 recommendations made by the Group included a recommendation that ‘the GMC make information about specialty registration and qualifications held by doctors more clearly available to the public on its website.

73. One way in which this has been done is by providing a link from the GMC’s website to the Department of Health guidance for patients seeking cosmetic surgery or non-surgical cosmetic treatments. However, more directly relevant to our review group was the work being undertaken Professor John Lowry, Chairman of the Cosmetic Surgery Inter-Specialty Committee (CSIC) of the Senate of Surgery of Great Britain and Ireland. The CSIC has responsibility for helping to take forward the recommendations of the Expert Group, and Professor Lowry, on behalf of the CSIC, gave evidence to our review.

74. We learned that the CSIC had been undertaking work on the education, training and assessment of practitioners carrying out cosmetic procedures. A framework had also been developed for procedure specific accreditation. In addition, consideration was being given to the establishment of an authoritative, overarching educational body (or ‘Academy’) to oversee the accreditation of cosmetic procedures and maintain lists of accredited specialists.

¹² The Care Standards Act 2000 requires all practitioners who work independently in private practice (except GPs) to be included in the specialist register, unless they were already practising cosmetic surgery before 2002 (when the Act came into effect). Doctors in this latter group who are not on the specialist register must, however, satisfy certain other criteria relating to their specialist training and practice.

75. Although further work remained, we noted the broad compatibility of CSIC's direction of travel, with the idea of specialist credentialing that we had discussed with others, such as the AMRC. The possibility of the GMC registering such specialist credentials as a means of providing a more up to date and meaningful description of doctors' specialist practice is discussed in the next section.

SECTION 8: Specialist credentialing

76. A specialist credential is a means of certifying the attainment of a standard of competence by an individual in a particular area of sub-specialty practice.

77. During our review we heard from a number of sources about specialist credentialing. In particular, we are grateful for the evidence received from Dr Mike Watson, Chair of the AMRC's CPD Sub-Committee. Although the development of specialist credentialing is still in its early stages, it offers a number of attractions in terms of registering specialist information.

78. First, registering specialist credentials would enable us to record competences acquired throughout a doctor's specialist career and not just at the award of a CCT (usually obtained after 3-5 years of specialist training). This is relevant since specialists may in future be undertaking a greater proportion of their advanced training following the award of a CCT. The register could therefore provide a more up to date statement of doctors' specialist competences.

79. Second, specialist credentialing might be used to reflect the increasing modularisation of specialist training and the more flexible training opportunities that will be necessary because of the changing demographics of the medical profession. Thus it might be possible to record in the register certain areas of competence obtained before the award of a CCT. This might also be relevant to doctors in career grade posts.

80. Third, credentialing would provide a way of giving formal recognition to the additional training undertaken and qualifications acquired by doctors.

81. Fourth, the recording of that additional training would make the expertise of specialists more easily recognised and the register more transparent.

82. Fifth, specialist credentials would enable the recognition of specialist competences in fields of practice for which it is not possible to obtain a CCT and where regulation has been identified as weak (such as cosmetic procedures and laser eye surgery). Work already being undertaken through the CSIC and the Royal College of Ophthalmologists suggests how this might be taken forward.

83. Sixth, credentialing offers a more agile means of responding to developments in medicine than is possible through the recognition of CCT specialties.

84. Seventh, it may be possible to extend the principle of credentialing to apply to general practitioners with special interests.

85. Specialist credentialing is not an immediate solution to the shortcomings of the specialist register. Further work will be needed to explore its feasibility and potential. Nor will it necessarily be appropriate for every specialty. We heard how in some areas of practice credentialing might be at odds with the need for broad based competences. It was not the task of this review to urge the development of specialist credentials, but to recognise that where appropriate credentials are developed, they may be used to add value to the information in the GMC registers. It seems likely that if specialist credentialing is to develop, it will do so slowly, initially within those specialties where there is a clearly defined need.

86. In section 11 we consider further how the idea of specialist credentialing might form part of the future development of the registers.

SECTION 9: The relationship between the registers

87. Once a doctor has been admitted to the specialist register he will remain on it as long as he remains on the medical register. Erasure from the specialist register follows automatically from erasure from medical register because medical registration is a pre-requisite for specialist registration. The only other circumstances in which a doctor might lose his specialist status are if his specialist register entry has been secured fraudulently or in error.

88. Further, the Medical Act 1983 is framed so that any sanction against a doctor's registration under the GMC's fitness to practise procedures is against the entry in the register of medical practitioners and not the entry in the specialist register. Under the law as it now stands, it is not possible to erase or suspend a doctor from the specialist register, but leave him on the medical register.

89. In *Good doctors, safer patients*, Sir Liam Donaldson recommends that the process of revalidation should have two components: a system of re-licensure that would determine a doctor's right to continue practising as a doctor, coupled with a system of re-certification which would determine a doctor's right to remain on the specialist or GP registers (recommendation 26). Under recommendation 31, Sir Liam goes on to explain that the process of re-certification will enable the GMC to maintain up-to-date specialist and GP registers with the confidence that specialists remain fit to practise.

90. *The GMC's Proposals on Healthcare Professional Regulation* support these recommendations, whilst noting that any proposal to act upon a doctor's

specialist or GP registration without affecting their standing in the medical register will have profound implications for the registration regime described in the Medical Act.¹³

91. Within the review, we endorsed the view that retention of a doctor's specialist status in the register (including any specialist credentials) must be contingent upon evidence of continuing fitness to practise to the appropriate specialty standards. As the GMC acknowledges in its response to Sir Liam's report, further work will be needed on the detail of how this is achieved.

92. The introduction of any such process must also have implications for the relationship between the registers in the context of the GMC's fitness to practise procedures. We noted two cases that illustrate the problematic nature of the existing connection between the registers.

93. In the first case, a doctor had been found guilty of serious professional misconduct and conditions were imposed on his entry in the medical register to the effect that he could not practice paediatric cardiac surgery for a period of three years. The doctor nevertheless remained on the specialist register in cardiothoracic surgery. In the second, more recent, case a consultant anaesthetist gave an undertaking to a fitness to practise panel to cease practising anaesthesia, but this did not result in his automatic removal from the specialist register in anaesthesia.

94. While the specialist register is no more than an historical record, this may be a tenable position. However, it will cease to be credible where the register is an up-to-date statement of a doctor's specialist competence. We considered that the ability to suspend or remove a doctor's specialist registration in such cases could also have the potential to send a stronger signal about the gravity of an offence than is currently possible.

95. We recognise that this proposal raises a number of complex issues (for example, the processes for assessing an individual's suitability to be restored to the specialist register and the future relationship between the registers and the licence to practise). These go well beyond the scope of this review.

SECTION 10: The purpose and regulatory effects of registering specialist information

Should there be a specialist register at all?

96. Earlier in this report we noted that EC law does not require us to hold a specialist register. Given the shortcomings of the specialist register and its limited utility for patients and the public, some have argued that it would be better for it to be abolished.¹⁴ We noted, however, that if this were to happen we would need to find an alternative mechanism for the recognition of non-UK

¹³ The GMC's Proposals on Healthcare Professional Regulation, GMC, 2006, p11.

¹⁴ Review of the fitness for purpose of the specialist register: Note of the GMC stakeholder seminar held on 3 October 2005.

specialist qualifications. The more practical and less disruptive option was to enhance the existing system rather than to start entirely afresh.

Purpose of registering specialist information

97. The review group noted how the original purpose of the medical register (to enable the public to distinguish the qualified from the unqualified) would be updated by the introduction of revalidation, re-licensing and re-certification, so as to provide confirmation that a doctor remains up to date and fit to practise.

98. In view of these considerations, we concluded that the registration of specialist information must fulfil two purposes:

- a. Meet the requirements of the law in relation to the recognition of specialist qualifications.
- b. Contribute to the health and safety of the community by enabling those consulting the registers to be assured of doctors' fitness to practise in their chosen specialist field.

99. The function of the registers containing specialist information should be to:

- a. Provide a public record of defined specialist and sub-specialist expertise acquired by doctors throughout their careers.
- b. Enable those consulting the registers to identify doctors eligible for independent specialist practice and selection for senior medical appointments.

100. The registers should not be used to provide information that does not reflect our regulatory purpose and which cannot be verified.

Privileges and regulatory effects

101. The regulatory effect of inclusion in the specialist register is that it is a necessary (though not a sufficient) condition for appointment to an NHS consultant post. The register also has an indirect effect in that, subject to certain exceptions, doctors can only gain admitting rights to independent hospitals if they are on the specialist register. In all other respects, the effect of the specialist register is indicative, rather than restrictive. As we have seen, the register indicates doctors' specialties, but does not limit them to working in those specialties. The question arises whether this indicative purpose continues to be appropriate.

102. We considered the proposition that as medicine fragments and the common skill base shared by all doctors declines, registration or licensure as a doctor would become less relevant than registration or licensure in relation to particular activities that individuals have shown they are competent to

undertake. This could point to a system of regulation that aimed to assure the public that a doctor was competent to do a particular job or perform a specified task. Doctors' practice might therefore be legally restricted to the field or fields in which they have demonstrated particular competences.

103. We noted that these arguments had been rejected by the GMC when they were raised during the first phase of the registration review. Instead, it was decided that registration should be generic and not restrict doctors to particular forms of practice. This was on the grounds that doctors are required by *Good Medical Practice* to recognise and work within the limits of their competence. A model that limited them to defined areas of practice was also likely to prove administratively burdensome, inflexible and prevent effective utilisation of the workforce, without increasing public protection. It might also stifle innovation if it became impossible for doctors to work outside of pre-determined and narrowly defined parameters. We therefore concluded that the regulatory effect of registering specialist information should continue to be indicative, not restrictive.

SECTION 11: A new model

104. This part of the report draws together the findings described in the previous sections and sets out our conclusions on a new model for registering specialist information.

105. As indicated in section 2, our proposals are not limited to the current specialist register as described by the 2003 Order. We have sought a model that will meet our additional needs without compromising our existing obligations.

106. In setting out this model, we recognise that there are a number of areas where further work will be required. Some of that work goes beyond the scope of the current review and will need to be taken forward in conjunction with our partners.

107. Our proposed model can be represented as a Venn diagram comprising three overlapping sets of information (Annex E):

Information Set A: the registration of workplace information describing doctors' scope of practice.

Information Set B: the specialist register.

Information Set C: the registration of specialist credentials.

108. Every registered (or in future licensed) doctor practising in the UK would be included in Set A. Some will also be in Set B and some in Set C. Some doctors will be included in all three Sets.

109. In addition to these three sets of information contained within the register, the GMC will be exploring ways in which it can use its unique database to carry additional information that would be of benefit to others in helping to protect and promote patient safety. These further uses of the GMC database go beyond the scope of this review and so are not discussed further in this report.

Information Set A: the registration of workplace information describing doctors' scope of practice.

110. In section 5 of this report we described the gap between what some doctors actually do and the specialties for which they are registered. By recording information about doctors' scope of practice we help to bridge that gap.

111. The scope of practice data to be collected from all doctors for the purposes of issuing the licence to practise would provide the basis for populating information set A. The proposal therefore involves no significant additional regulatory burden for either doctors or the GMC.

112. Doctors will self-declare their scope of practice. The information would be corroborated through sampling and the clinical governance sign-off required to secure successful revalidation. The recording of this information on the face of the register will enable doctors to show the fields of practice in which they have been practising without cause for concern.

113. Since Set A information relates to the workplace and scope of practice, it would only be possible to register information relating to UK medical practice. The registration of Set A information relating to practice outside the UK would be inappropriate because it could not be readily verified.

114. One of the attractions of Set A information is that it tells those consulting the register what a doctor actually does. It also allows the recording of specialist activity in fields in which specialist credentials (see information Set C) may not yet have been developed, but where an individual is practising without cause for concern.

115. The registration of workplace information in Set A would not require inclusion in the specialist register (Set B) or possession of a registered specialist credential (Set C).

Information Set B: the specialist register

116. The function of the current specialist register would remain unchanged. It would continue to be the mechanism for recording the attainment of a CCT and be the means of registering European specialist medical qualifications and 2003 Order Article 14 training and experience. Inclusion in the specialist register would continue to contribute to eligibility for senior medical appointments.

117. However, specialist registration should be uncoupled from registration in the register of medical practitioners so that it is possible to lose specialist registration status either through the GMC's fitness to practise procedures or through failure to maintain specialist certification.

Information Set C: registration of specialist credentials

118. The third information set would contain registrable specialist credentials.

119. As we have acknowledged in Section 8 of this report, further work is needed to develop the thinking around specialist credentialing, its relationship to existing specialties and sub-specialties, and future quality assurance. This work goes beyond the scope of the present review, which is concerned with the meaning and maintenance of the registers. Nor is it just a matter for the GMC, but also for PMETB, the AMRC, individual medical Royal Colleges, specialist societies and other competent bodies. That work is already underway.

120. In the meantime, for the purposes of our review it has been necessary to consider how a credentialing regime could be incorporated into the registration system.

121. We have defined a registrable specialist credential as a body of knowledge and skills acquired and maintained across a defined area of medical practice within a recognised specialist field in the UK. That knowledge and those skills would be determined by the competent UK body in the relevant specialty at the level necessary to allow independent medical practice in the credentialed field. There would need to be a single competent body in each field so as to avoid the multiplication of similar and competing credentials.

122. Credentials that describe a single competence or are procedure specific are likely to be inflexible and would quickly become out of date as a specialty developed. They would also result in a plethora of very narrowly defined credentials that are difficult to regulate. A registrable credential should therefore cover a broader sub-specialty field.

123. The development of credentialing must be compatible with the PMETB's existing powers in relation to the recognition of sub-specialty training and the registration of sub-specialties in the specialist register. Article 13(4)(b) of the 2003 Order states that the register shall include the specialty for which a person is registered and, where the PMETB is 'satisfied that he has particular expertise in a field within that specialty...a description of that field'. A specialist credential could not be established in competition with PMETB approved sub-specialty training in an identical field. However, a specialist credential might emerge as a sub-set of an approved sub-specialty.

124. Credentialing is usually discussed in terms of post-CCT specialisation. We take the view that the development of competency based training modules would make it possible to apply the principle of credentialing for any stage of a doctor's career. This might also make credentialing attractive for doctors in career grade posts. However, compatibility with PMETB regulated training would again be essential. Any credential in a field covered by a specialist training programme leading to a CCT would have to follow the same curriculum and indicate the same standard of achievement as the relevant PMETB programme.

125. We also saw the development of registrable credentials as applicable to the development of the GP register for GPs with special interests.

126. Once a specialist credential has been obtained, it must also be maintained. In the same way that retaining an entry in the specialist register will in future require doctors to demonstrate that they are continuing to practise to the relevant specialty standards, doctors will also need to demonstrate the competences necessary to retain a credential. The evidence of maintenance of a credential would contribute to a doctor's revalidation.

127. A doctor might hold one or more registered specialist credentials. However, a credential would become dormant in the register if the doctor could not demonstrate that it was being satisfactorily exercised. A dormant credential could be re-activated by demonstrating that it was being maintained to the appropriate standards.

128. Doctors holding a registrable specialist credential would be eligible to have that credential appear in their register entry. Registration of credentials would be voluntary.

129. Unlike inclusion in the specialist register, possession of a registrable credential would not confer any direct regulatory privileges. Instead, the effect would be indicative. It would simply show employers and the public the areas in which a doctor is currently maintaining specialist competences. We recognise, however, that there is likely to be an indirect regulatory effect in that, over time, employers may come to expect individuals whom they are thinking of appointing to have the relevant registrable credentials. It would, therefore, be in a doctor's interests to demonstrate and register his specialist credentials.

SECTION 12: *Good doctors, safer patients, and Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*

130. Sir Liam Donaldson's report *Good doctors, safer patients* was published in July 2006, mid-way through our own review. Since the conclusion of our review the Government has published its response to Sir Liam's proposals, in the White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. The Government's conclusions

largely endorse Sir Liam's recommendations in relation to the future of the specialist and GP registers

131. At various points in this report we have touched on the implications of Sir Liam's recommendations for our own work. We are confident that the proposals discussed in our report are entirely compatible with the recommendations affecting specialist registration contained in *Good doctors, safer patients* and in the Government's White Paper proposals. Indeed, in terms of the new registration model outlined in Section 11, we have gone somewhat further.

132. In recommendation 38 of his report, Sir Liam states that the medical register should be the key national list of doctors entitled to practise in the UK and should contain tiers of information (some publicly available, some restricted) about each doctor and their standard of practice. Under recommendation 39 he describes the type of information that needs to be available so that 'the public and prospective employers have access to meaningful information'. These themes are echoed in chapter 6 of the White Paper.

133. The issue of developing tiers of information has been tackled by the GMC separately from the present review of the specialist register. The starting point for our review was the need to make a wider range of information available through the registers in a way that met the needs of our stakeholders. Our proposals in relation to the registration of specialist credentials set out how this might be done. At the same time, we have identified a need to give greater clarity to the information in the existing specialist register in order to make its meaning more transparent.

134. In recommendations 26 and 31 of his report, Sir Liam proposes a system of re-certification for specialists and GPs that will enable the GMC to maintain up to date specialist and GP registers (White Paper, chapter 2). In sections 8 and 11 of our report we discuss mechanisms to ensure that the registers are able to provide confirmation of doctors' continuing fitness to practise in their chosen specialist field.

SECTION 13: Legislative implications

135. Our remit requires us to consider whether amendments are needed to legislation in order to meet our objectives. It would be premature at this stage to provide a detailed breakdown of the required changes. However, a preliminary analysis of some of the key considerations is set out below.

136. Section 30(3) of the Medical Act 1983 provides that the registers shall include 'such of their qualifications as [doctors] are entitled to have registered under section 16 or 26 [of the Act] and such other particulars (if any) of those persons as may be prescribed for that register'. The particulars 'prescribed' for the register are set out in regulations made by the GMC. The inclusion in

the register of scope of practice information (Set A information) and specialist credentials (Set B information) is likely, therefore, to require amendment to both the Act and to supporting regulations.

137. Article 90 of the Medical Act 1983 (Amendment) and Miscellaneous Amendments Order 2006 gives the GMC a power to collect information from doctors for the purposes of revalidation. The GMC already intends to use this power to enable it to collect information from doctors about their scope of practice. This will provide the basis for the information collected for Set A.

138. The principal UK legislation governing the operation of the specialist register is the Medical Act 1983 and the 2003 Order. As discussed in Section 9 of this report, the introduction of a system for re-certifying entries in the specialist and GP registers would require changes not only to those registers, but to the legislation affecting the relationship between the specialist and GP registers and the register of medical practitioners, and the licence to practise. The scope of the required changes should not be underestimated.

139. We have considered whether the introduction of credentialing could have implications in terms of EC law and the free movement of professionals. We believe that our proposals for specialist credentialing would not offend EC law because their regulatory effect is entirely indicative. They provide a statement of competence in a particular area of sub-specialty practice, but they are not a legal requirement for entry to specialist practice. It is in fact quite possible that specialist credentials could be secured through competences obtained overseas. During the course of our review we learned of one specialty that is already working to develop specialist credentials recognised at a European level against a common standard.

SECTION 14: List of recommendations

Purpose and scope of the registers

Recommendation 1: The current purpose of registering specialist information must be broadened to fulfil two objectives:

- a. Meet the requirements of the law in relation to the recognition of specialist qualifications.
- b. Contribute to the health and safety of the community by enabling those consulting the registers to be assured of doctors' fitness to practise in their chosen specialist field.

Recommendation 2: The functions of the registers in relation to providing specialist information should be:

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- a. Provide a public record of defined specialist and sub-specialist expertise acquired by doctors throughout their careers.
- b. Enable those consulting the registers to identify doctors eligible for independent specialist practice and selection for senior medical appointments.

Recommendation 3: Specialist information contained in the registers should be indicative in its effect. It must facilitate doctors in working within the limits of their competence, and not impose barriers that unnecessarily inhibit the flexibility of the workforce.

Content of the registers

Recommendation 4: Specialist information contained in the registers must be verifiable and reliable. This is central to the registers maintaining their authority and integrity.

Recommendation 5: The meaning of the information contained in the specialist register is unclear and potentially misleading for patients and the public. The range of specialties described (currently around 270) needs to be rationalised and the significance of the information made more transparent for those consulting the registers.

Recommendation 6: The GMC should not use the specialist register to provide a wider range of consumer information for patients and public. This is not the purpose of the registers and the information can be more appropriately provided through other sources.

Recommendation 7: The GMC should develop its role in helping to direct patients and the public to other sources of specialist information that it cannot itself provide.

Recommendation 8: The GMC should increase awareness of its registers by working with other organisations to provide links to its registration database.

Recommendation 9: The registers should be extended to allow the inclusion of additional information about doctors' sub-specialty expertise. Such information will be of particular use to employers and other healthcare providers. This information could be provided through the development of registrable specialist credentials (see recommendation 12 below).

Recommendation 10: Retention in the specialist and GP registers should be contingent upon doctors demonstrating that they remain up to date and fit to practise in their chosen specialty.

Recommendation 11: The scope of practice data that the GMC will collect from doctors to support licensing and revalidation should be included on the registers.

Organisation of the registers

Recommendation 12: The registers should provide three overlapping sets of information:

Information Set A: workplace information describing doctors' scope of practice.

Information Set B: details of entries in the specialist and GP registers.

Information Set C: details of registered specialist and GP credentials.

The inclusion and retention of information in Sets B and C should be subject to demonstration of ongoing fitness to practise in the relevant field.