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## **4bi**

*To consider*

### **Specialist Register and Recertification**

#### **Issue**

1. Making the specialist register meaningful. This paper builds on the ideas of item 4bi to explore the possibility of using information about doctors' scope of practice to support recertification.

#### **Recommendations**

2.
  - a. To agree that we should address the fitness for purpose of the specialist register in the light of the 2006-2007 review and the development of recertification (paragraphs 16-20).
  - b. To invite the Registration Reference Group to review the fitness for purpose of the specialist register in the light of the 2007 report and the development of recertification. (paragraphs 21-22).

#### **Further information**

3. If you require further information about this paper, please contact us by email: [gmc@gmc-uk.org](mailto:gmc@gmc-uk.org) or tel. 0161 923 6602

## Background

4. We maintain three registers:
  - a. The register of medical practitioners (the medical register): A doctor must be on the medical register to practise medicine in the UK. There are around 240,000 doctors on the medical register.
  - b. The specialist register, introduced in 1996: A doctor must be on this register in order to take up appointment as a consultant in the NHS. There are around 60,000 doctors on the specialist register.
  - c. The general practitioner register, introduced in 2006: A doctor must be on the GP register to work as a GP in the NHS. There are around 60,000 doctors on the GP register.
5. Not all of the information contained in our registration database is publicly accessible. There are three tiers of information:
  - a. Information that is publicly accessible through our website, such as registration status.
  - b. Information provided on a restricted basis, such as information given to employers about a current fitness to practise investigation.
  - c. Information confidential to the doctor and the GMC, such as annual retention fee payment details.
6. Under the Medical Act 1983, we are required to publish a list – the List of Registered Medical Practitioners – of those who are registered, information about their registered qualifications and details of any fitness to practise sanctions. The LRMP includes whether a doctor is registered and, if so, whether they are also on the specialist register or GP register.
7. Licences to practise will be introduced in Autumn 2009. At that point, the LRMP will be modified to show for each registered doctor whether they have a licence to practise.
8. Revalidation will be a single set of processes leading to two possible outcomes - relicensing and, for doctors on the specialist register or GP register, recertification.
9. The purpose of recertification is to enable doctors on the specialist register or the GP register to demonstrate that they continue to meet the particular standards that apply to their medical specialty, including general practice.

10. We must be able to describe the relationship between ‘certification’, that is admission to the specialist register or GP register, and ‘recertification’. This is currently complicated by the fact that PMETB approves the standards required for a Certificate of Completion of Training, whereas we will approve the standards required for recertification. The complication will be addressed by the merger of PMETB with the GMC.

11. Meanwhile, we have been working with the Academy of Medical Royal Colleges on the development of recertification. The Working Group has agreed that:

a. It is for the medical Royal Colleges and Faculties to propose the standards for recertification and to design appropriate evaluation tools.

b. The standards for recertification will be those required for entry at the time to the specialist register and the GP register. However, for recertification, the range of competencies to be demonstrated may be narrower, reflecting increased specialisation over time.

c. It is for the GMC to approve the standards proposed by the medical Royal Colleges and Faculties for recertification.

d. For doctors in active medical practice (both clinical and non-clinical) in the UK, the principal evidence for recertification should be derived from actual medical practice, generated from within the workplace locally through appraisal.

e. Relicensing and recertification would draw upon largely the same evidence.

f. Recertification must command the confidence of our key interests.

12. 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’).

13. The form and content of the specialist register is prescribed in the 2003 Order. It must include the specialty in respect of which a 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 they have particular expertise or have completed the appropriate sub-specialty training.

14. In 2006-2007, we surveyed 1,250 doctors on the specialist register. 86% of respondents were working exclusively in the specialty listed in the specialist register, or in a sub-specialty of that specialty; 4% were working in a wholly different specialty; and 10% were working in their registered specialty and in another specialty.

15. The UK awards Certificates of Completion of Training (CCTs) in 58 specialties. However, some 300 specialties appear in the specialist register, partly because of transitional provisions when the specialist register was introduced and partly because the 2003 Order empowers PMETB to award Certificates of Eligibility for Specialist Registration in specialties other than those in which the UK awards CCTs.

## Discussion

16. The specialist register and the GP register have different and distinct effects:
- a. Doctors must be on the GP register to work as a GP in the NHS, whereas doctors must be on the specialist register to be appointed as a consultant (other than a locum consultant) in the NHS. Doctors do not have to be on the specialist register to work as a consultant in the NHS; and some consultants are not on the specialist register, having been appointed before it was introduced.
  - b. The GP register creates a clear link between the speciality of qualification and the speciality of practice, namely general practice, whereas the specialist register creates no such link. A doctor on the specialist register is not confined to appointment to, or employment in, the speciality or specialities listed in the specialist register.
17. In 2006-2007, we undertook a review of the fitness for purpose of the specialist register, 10 years after its introduction. The report of the review (*Accessible, Transparent, Informative: Proposals for Registering Information about Specialist Medical Practice*) can be found on our website at [www.gmc-uk.org/about/council/papers/2007\\_04.asp](http://www.gmc-uk.org/about/council/papers/2007_04.asp).
18. Because of the timing, the review was unable to take account of the emergence of recertification as one of two components of revalidation. The Council concluded that action on the report should be deferred until our thinking on recertification had developed.
19. There are clear arguments for returning to the fitness for purpose of the specialist register – the evident appetite in the NHS and other healthcare providers for more information about doctors' current practice; the need to be able to articulate clearly the relationship between initial entry on the specialist register and recertification based on evidence derived from current practice; and the need to address, or to be able to explain, the differences in effect of the specialist register and the GP register respectively.
20. We believe that the development of recertification argues for returning to the issues now.

**Recommendation:** To agree that we should address the fitness for purpose of the specialist register in the light of the 2006-2007 review and the development of recertification.

21. If Council accepts this recommendation, we will need to take the work forward in conjunction with the Academy and PMETB, taking full account of the needs of patients and the public, and the NHS and other healthcare providers. The Continued Practice Board will also have an important contribution to make.

22. The aim would be to bring provisional conclusions to Council as a basis for consultation with all our key interests.

**Recommendation:** To invite the Registration Reference Group to review the fitness for purpose of the specialist register in the light of the 2007 report and the development of recertification.

### **Resource implications**

23. Additional costs for the Registration Reference Group will be marginal. Some costs will arise to support effective engagement; and there may be a case for survey or other work as a means of establishing the needs of patients and the public and of the NHS and other healthcare providers. The costs should not exceed £10,000.

### **Equality implications**

24. None at this stage. Proposals for change will be subject to an equality impact assessment.