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Revalidation and medico-legal practice after retirement

Traditionally, many consultant orthopaedic surgeons have retired from clinical practice and supplemented their pensions in retirement by continuing their medico-legal practice. The longevity of this custom has varied enormously from surgeon to surgeon. There has been no clear monitoring of the situation after retirement in terms of currency or quality of work, other than the fact that if solicitors/insurers continued to issue instructions to the individual then it was presumed that the quality and content of the reports and expert opinion provided were fit for purpose.

Then along came revalidation in 2012. I discussed some of the prevalent issues on the subject in an article published in this journal a year ago.[1] This brief article should be seen as an update and considered together with the earlier piece.

It has been difficult to get a clear position statement from the GMC on this matter, but my understanding remains that if an orthopaedic surgeon is interviewing and examining patients (claimants), he/she is required to maintain GMC registration and hold a licence to practice. In order to do this, the surgeon needs to undergo annual appraisal and revalidate every five years in exactly the same way as they would be required to do when in active (NHS or private) practice. The Medical Defence Union appears quite clear on this, stating, "Some doctors undertake medical expert report writing after they have retired from normal clinical practice. To maintain their credibility in court, such doctors retain a licence to practice medicine and to do that they have to revalidate with the GMC."[2]

However, it is *not* exactly the same because after retirement, contact with the NHS Trust is often lost and therefore the appraisal link through the head of department and the responsible officer, usually the medical director of the Trust, is no longer available to them. Senior orthopaedic surgeons might usefully build bridges to maintain an active link with their Trust prior to retirement, to facilitate an honorary contract on the basis of a teaching or regular multi-disciplinary meeting attendance. This would maintain contact and provide a continuing link for appraisal and revalidation.

The BOA recently asked members for feedback and comment on revalidation issues after retirement. A number of responses were received with some common themes:

1. The main single issue that concerned respondents was the lack of clarity on what was actually required after retirement in order to continue in medico-legal practice. A significant issue was the apparently conflicting advice provided by the GMC itself. A number of retired BOA members had been told that a licence to practice was not necessary only to find that this was incorrect. They have then had to negotiate various hurdles to have their licence reinstated.
2. Suggestions where help/assistance with appraisal after retirement from the NHS may be found. The main recommendation was the Independent Doctors Federation (IDF) (www.idf.uk.net) which is described as "very helpful and efficient", although the costs are "not inconsiderable."
3. Offers of help from individual registered appraisers.
4. Criticism of the quality of work and longevity of some retired orthopaedic medico-legal practitioners with the view that if a surgeon is unable to appraise and revalidate through a recognised hospital process, he/she should not be working as an expert.

The Faculty of Forensic and Legal Medicine (FFLM) has some useful information on its website (http://fflm.ac.uk/revalidation/faq/). They point out that all doctors who have a licence to practice must revalidate and therefore require annual appraisal. They discuss how there are different types of expert medical reports which require different considerations. They give the example of the retired orthopaedic surgeon who only occasionally provides expert opinion on the standard of care that would have been considered

appropriate when he/she was in active clinical practice. They believe that it is not necessary to retain a licence to practice solely for that purpose. The expert opinion would presumably be given from the records and witness statements without any requirement to interview or examine the claimant.

The point is strongly made that if the retired orthopaedic surgeon makes themselves available for providing such opinions, he/she must:

1. Make it absolutely clear to the instructing party, and prominently state in the substance of the report, that they no longer hold a licence to practice medicine.
2. Make sure that their medical defence organisation subscription is appropriate for the type of work they are carrying out, and that their indemnifying organisation is aware that they do not hold a licence to practice.

With regard to expert 'desk top' reports on contemporary practice or clinical conditions, a requirement for a licence to practice is "almost certainly" necessary. By 'desk top' report, I refer to reports provided without the need to interview or examine the claimant. The FFLM point out that the lack of a licence to practice is likely to attract criticism during court proceedings if a case in which the individual was acting as an expert was to proceed that far. I am sure the instructing party would also be severely criticised by the court if they were found to have instructed an individual without such a licence.

Any medical report which requires a medical examination to give a view on current condition and prognosis mandates a licence to practice. Courts and tribunals would be unhappy to rely on expert evidence provided by an expert without such a licence. Carrying out such interview and examination of a claimant without a licence to practice could also give rise to issues of probity.

Another relevant point is made on the FFLM website in relation to the revalidation process concerning the legal privilege (in addition to medical confidentiality) attached to expert medical reports. This means that the retired orthopaedic expert would need to get proper consent before disclosing evidence of his/her work to their appraiser or responsible officer. This would involve obtaining written consent through the instructing party. Advice may also need to be taken from the instructing party as to whether consent to disclosure is required from any other party to the action.

CONCLUSION

The current situation post-retirement in the UK is that to continue acting as an expert witness, it is necessary to stay on the medical register and hold a licence to practice. This means annual appraisal and revalidation, as for all other medical professionals, except in the rare situation referred to above where there is no patient/claimant contact, and 'desk top' work is done considering practice at the time that the orthopaedic surgeon was registered, and in active clinical practice. There is no way around this.

REFERENCES

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