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Appraisal and revalidation after 'retirement' from clinical practice

It is generally accepted that it is a shame to lose the experience and wisdom gained during a career as an orthopaedic surgeon when a consultant retires from NHS or from private practice. Discussions surround the longevity and currency of such wisdom and experience after retirement. Retired consultants may, if they wish and if their colleagues allow, continue to be involved with teaching, multidisciplinary team (MDT) work, and so on. An honorary contract at the base NHS hospital will probably have to be negotiated to allow this. This may confer the right to continue to be appraised at the base hospital. More usually, consultants wish to continue carrying out medico-legal work after retirement both to act as a means of phasing their retirement and to supplement their pension.

In the latter situation, they will have to make alternative arrangements for annual appraisal. If they hold practising rights at a private hospital or clinic, then they may be able to organize appraisal through the hospital group, with the medical director of that group acting as their responsible officer (RO) when it comes to revalidation with the General Medical Council (GMC). Alternatively, they may join organizations such as the Independent Doctors Federation (IDF) that offer the facility for annual appraisal (at a charge in addition to the annual membership of £225/£325), and also have an appointed RO.

Writing this article was prompted by a letter from a senior British Orthopaedic Association (BOA) member who contacted me recently indicating that he had retired from the NHS in April 2013, having revalidated in March 2013. Following retirement, he gave up all clinical work but continued in medico-legal practice interviewing and examining patients at the local private hospital where he had practising rights. He completed annual appraisals through the private hospital on an annual basis after retirement from the NHS with the intention of being revalidated and remaining on the medical register from March 2018. He was informed by his appraiser in 2016 that, as his practice was not of a clinical nature, he would not need direct feedback from patients by way of a patient survey. He also discussed quality improvement with his appraiser, who suggested that there should be a review of joint statements that had been prepared on medico-legal cases. He estimated that he had taken part in around ten discussions leading to joint statements in the previous three years. He was unclear on the benefit of such a review as, having reviewed the joint statements, he found that generally there was little disagreement between himself and the opposing expert in these statements.

In March of this year, two weeks prior to revalidation, he was contacted by his RO, who told him that the appraisal was to be deferred because he had not carried out a patient survey and had not done enough to satisfy him that there was evidence of quality improvement in his medical practice. He was directed to the GMC documents on good medical practice and guidelines for appraisal,[1,2] particularly those regarding quality-improvement activities. He was told that, for the purpose of revalidation, he would have to demonstrate that he regularly took part in activities that review and evaluate the quality of his work and that, "Quality improvement activities can take many forms, depending on the role you are undertaking and the work that you do. If you work in a non-clinical environment you should participate in quality improvement activities relevant to your work." He was referred to the following areas in the GMC guidelines and made the following points:

1. Clinical audit: as he sees no patients, it is not possible to carry this out.

2. Review of clinical outcomes: as he treats no patients, there are no clinical outcomes.
3. Case review and discussion with a documented account of difficult and interesting cases that he may have discussed with his peers: in the medico-legal setting, he is not obliged to discuss any cases with peers and, in any event, the cases are confidential.
4. Audit and monitor the effectiveness of a teaching programme: he is not involved with a teaching programme and therefore cannot audit or monitor the effectiveness of a programme that does not exist.
5. Evaluate the impact and effectiveness of a piece of health policy or management practice: he did not see how this would fit into his practice, which is now purely medico-legal and solely concerns breach of duty.

The member and I liaised on the above issues and the GMC guidelines together with the position taken by his appraiser/RO. We noted that the Royal College of Psychiatrists (RCP) have published a guidance note on revalidation for medico-legal doctors, which points out that, "There is absolutely no reason why you cannot revalidate if you are doing exclusively medico-legal work and it is now clear that you will not realistically be able to do this work for any period of time unless you have a licence to practise. This is primarily because the medical defence organisations require this, but also because from a purely pragmatic point of view failure to be licensed will quickly erode your competitive edge with solicitors."[3] Furthermore, they point out that practice has to be interpreted in a wider context than just clinical practice, and that the concepts that the GMC associates with "patients" have to be extended to claimants. The RCP guidance note continues, "Because of the particular circumstances of medico-legal work, the doctor has a dual responsibility, to the person being interviewed and also to the instructor and others involved in the Court or Tribunal process. It is therefore important that any feedback you choose to present takes this into account."[3] Clearly, as orthopaedic experts, we need to accept and recognize that our primary responsibility is to the court and not to the claimant or the instructing party. However, the claimant has to be treated with dignity and respect, irrespective of which side has instructed the expert, and the instructing party has to be dealt with professionally and courteously.

The RCP helpfully consider some of the areas that our member's appraiser/RO referred to above, making the following suggestions:

1. Continuing professional development: this should include regular updates in witness skills, new protocols, relevant case law, and Continuing Professional Development (CPD) events on medico-legal topics in general. An awareness of the impact of the discount rate change[4] and its impact for malpractice insurance and negligence litigation in general could be discussed.
2. Quality improvement activity: this can include reflections on improvements gained by reading other experts' reports, meetings of experts, and preparation of joint statements, as well as the effects of testing your evidence in conference or court. Case-based discussions with other experts around medico-legal issues are also included here. Although the cases are confidential, the details can be anonymized.
3. Significant events: possible events could include missing a critical alternative or contrary opinion that is exposed in the conference or court stage of the examination of evidence. It could equally refer to events during the interview, such as the interviewee walking out and refusing to return.
4. Feedback from colleagues: this must include feedback from lawyers (ideally including barristers and, where appropriate, judges). If you work with other professionals or staff, their views must also be included.
5. Feedback from patients: this is interpreted as the person whom the doctor interviews for the purposes of preparing a medico-legal report, i.e. for "patient" read "claimant". In the same way that the GMC form asks for feedback immediately after a consultation, it is recommended that this is the format adopted in medico-legal practice, so that the feedback examines the style of the interview and not any opinions expressed in the report.
6. Review of complaints and compliments: any letters received from solicitors and barristers or comments made by judges that are available in writing should be included here, together with any reflections or actions taken as a consequence.

Therefore, by taking the above factors into consideration, it should be possible to create a portfolio of documents relating to your medico-legal practice that will satisfy your appraiser. As part of this portfolio, it is important to provide evidence of ongoing CPD. Patient/claimant feedback provides more of a practical problem, as the patient questionnaires provided by the GMC[5] and Edgecumbe[6] ask a number of questions that are largely irrelevant in the medico-legal environment because they relate to proposed investigation and treatment. Therefore, we may need to design a form that is more specific to doctors who are working solely as expert witnesses after retirement.

In essence, it seems that we need to recognize, as the RCP have done, that it is appropriate for experienced/retired orthopaedic surgeons to work exclusively in the medico-legal field and to be appraised and revalidated on that basis. As discussed at the outset, there is more controversy over the longevity of the retired expert's opinion after retirement. However, it is difficult to see how an expert could be criticized by the court or legal profession in terms of his/her professional standing if he/she is annually appraised, engages in the appropriate CPD/Continuing Medical Education (CME), and holds a certificate of revalidation, and if his/her name is on the medical register.

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