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Reregistration of medical specialists in the Netherlands

J A Swinkels

Since 1991 all specialists in the Netherlands have had to get reregistered every five years in order to retain their place on the medical register. Although the criteria for reregistration were initially solely quantitative, being based on a minimum number of hours spent in specialist practice, qualitative criteria have now been introduced. A new law which is expected to come into force in January 2000 requires doctors to complete 40 hours a year of accredited continuing medical education or to be assessed in the workplace every five years. In practice, however, most specialist societies are requiring their members to fulfil both of these requirements in order to reregister.

Methods

This article is based on my experience as chairman of the committee on quality of care and member of the council on quality, science, and education of the Dutch Association of Medical Specialists (Orde van Medisch Specialisten) and on key references relating to quality management. Further information was obtained through a net search (www.artsen.net).

From registration to reregistration

The training of medical specialists is organised by three different bodies: the central board for the recognition and registration of medical specialists, the specialist registration committee, and the committee of appeal. The central board formulates the training requirements. Members are recruited from the scientific societies and the medical faculties, and representatives from the government participate in the meetings. The specialist registration committee keeps the register of doctors and ensures that the training requirements for candidates are met and that the training facilities and trainers meet the required standards. It also supports trainees. The committee of appeal is an independent body that deals with any conflict.

The formal reregistration system was introduced in 1991 to accommodate the growing need for external accountability, the ageing of specialists, and the notion that doctors should stop practising at 65, the rapid expansion of medical knowledge and technology, and the expansion of activities to assure the quality of specialist care, such as continuing medical education and peer review. At that time discussions were also taking place about a new law on professional practice with consequences for the system of professional titles.

Reregistration was linked to the existing system for the registration of specialists. Initially the criteria were exclusively quantitative, being linked to the amount of time spent in practice. For example, surgeons could remain on the register if they had done at least 20 hours of surgery a week in the past five years and psychiatrists had to have practised for at least 8 hours a week. The scientific societies of medical specialists were invited to develop qualitative criteria for assessing medical performance. In 1986 the Dutch council for public health published a report on the quality of professional medical performance which can be seen as an organising principle for the qualitative criteria for reregistration. Three dimensions were distinguished which covered all aspects of doctors' work (box). Some of the activities were already done voluntarily and others are enforced by law. Peer review of specialists was established and accepted by all parties, including the government, in the 1970s. The Institute for Quality in Health Care was established in 1976 to support peer review. It is financed by a supplementary charge on the daily price of hospital beds. Visits to the place of practice guidelines—This is now done voluntarily by almost all the scientific societies, supported by the Dutch Association of Medical Specialists

• Peer assessment in workplace

Summary points

• Reregistration compulsory since 1991
• Reregistration initially based on minimum time in practice
• Qualitative criteria to be introduced in 2000
• 40 hours/year of continuing medical education required
• Peer assessment in workplace

Dimensions for qualitative assessment

Technical-methodological

• Development of practice guidelines—This is now done voluntarily by almost all the scientific societies, supported by the Dutch Association of Medical Specialists
• Peer review (quality of technical performance) by medical audit
• Continuous medical education—Voluntarily done by almost all the scientific societies
• Training of medical specialists—Since 1966 training hospitals have been assessed and regulated by the central board and specialist registration committee

Interpersonal process

• Patient information and education
• Communication between doctors
• Peer review by medical audit on and training in attitude and communication

Organisational

• Visits to the medical practice (organisation) by peers in and outside hospitals
One hundred years ago

Treatment of shock

The deadliest morbid conditions are not always associated with proximity to a hospital where experts are ever ready with special apparatus to counteract them. Again, those appliances are usually complicated and often failures. What surgery demands is the simplest method for overcoming the worst possible complications. Shock, haemorrhage, or sepsis may occur far from hospital aid leaving the patient in the hands of a practitioner of average ability himself far from his own surgery. Arm-to-arm transfusion of blood to counteract shock from loss of that fluid is not easily managed except by expert surgeons, and is now rejected by them as actually dangerous. Transfusion of “artificial serum,” or saline solution, into the veins of the arm, as simplified by Dr. Horrocks and others, has saved many lives in hospital and surgical practice. But it is a step from which the practitioner may, for several reasons, recoil. Transfusion of saline solution into the subcutaneous tissue is much easier, and the Baltimore school find it quite efficient. But of late several operators have taken to the use of enemata of saline solution. At first the enema was looked on as a mere adjunct to transfusion, venous or subcutaneous. Now it seems to be considered to be as useful as the more difficult process. Lépine, of Lyons, as the result of observations, concludes that whilst subcutaneous injection of saline solutions is quite as good as intravenous injections, saline enemata are as efficient as the former. He finds that the rectal mucous membrane absorbs the solution at least as speedily as does the subcutaneous connective tissue. What is quite as important is that clinically the effect of absorption by the rectum is the same, and appears just as quickly as the effect of absorption by the subcutaneous tissues. Lastly, those effects are in the case of enemata, as in the case of the less simple appliances, beneficial alike for shock, for sepsis, and for haemorrhage. (BMJ 1899;2:672)